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SOME OF THE PROBLEMS OF THE ALIENIST.[1]

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Mr. President and Members of the American Medico-Psychological Association:

The invitation to deliver the Annual Address before the American Medico-Psychological Association both delighted and alarmed me. I cannot say how deeply I appreciated the honor which had come to me so unexpectedly from this notable body of alienists, but I felt all the more keenly those misgivings that must naturally arise in the mind of one who is asked to follow in the footsteps of several distinguished predecessors. What could I say to you of psychiatry, that science wherein your own experience so far outrivals mine? What new thing could I bring you from the domain of neurology, that would be helpful, interesting or inspiring? The more I revolved the problem in my mind, the more perplexed and apprehensive I became. I recalled the trend of similar addresses on former occasions, which dealt mainly with the relations of the neurologist to the alienist and with the progress of psychiatry, and these subjects were so well and so exhaustively presented, that I gained no solace from a contemplation of their well-worn texts. So finally turning from the field of things

[1] Annual address delivered at the meeting of the American Medico-Psychological Association at New York, May 24, 1899.

already accomplished, both in the practical care and treatment of the insane and in the scientific investigation of brain and nerves—noteworthy, fascinating and wonderful as your progress herein has been—I gave wings to imagination, wings somewhat inefficient, it is true, and let it roam the region of unsolved difficulties and undiscovered things. The progress of the past century in every department of human knowledge and undertaking is familiar to us all. Step by step, every decade of years with an added impetus, has this progress been made. The development of our modern hospitals for the insane and the accumulation of facts in respect to the nervous system, are but a small part of this marvelous evolution of mankind and civilization, a small part by contrast with the whole, yet great indeed when viewed alone. Since so much has been done in these hundred years, what is foreshadowed for us in the century to come?

Meditating in this wise, my text suggested itself:

"SOME OF THE PROBLEMS OF THE ALIENIST."

These problems are of two kinds, first the practical ones which have to do with the methods of care and management of the insane, secondly, the scientific, which look for solution to the clinic and to the laboratory.

I need not say with what respect and admiration I have witnessed during these twenty years the improvements you have wrought in your hospitals, improvements in structure, advances in economical means and devices, reforms in the laws relating to the insane, successful efforts to abrogate political influence in administration, and betterments in the methods of study, care and treatment; nor need I here refer to the remarkable awakening in every hospital for the insane in the Union to the importance of modern scientific research, as evidenced by the establishment of laboratories and the employment of psychologists, pathologists and chemists to further the good work. It is therefore in no spirit of criticism that I seek to discover and discuss within the limits of this brief address the lines of future progress, but rather with the feeling that whatever ideas I may express as to the possibilities of the future only reflect a similar and simultaneous prevision in you, who, more than I, are cognizant of the present de-

ficiencies of psychiatry and alive to the potentialities of the morrow.

THE PRACTICAL PROBLEMS.

As regards then, first, the material welfare of the insane, let us suppose that there is a populous State or country in which as yet no public provision for the insane has been made. We are consulted as to the best methods of care in the light of past experiment elsewhere and present knowledge. We shall find in this hypothetical community, where no asylums as yet exist, that the subacute and chronic insane are provided for in jails and almshouses, and the acutely insane to a certain extent in general hospitals and a few scattered retreats in the hands of private individuals or corporations. What will be the ideal method of State-care (for it should be State-care) for such a commonwealth to adopt? It has long been an axiom among asylum physicians that early diagnosis and speedy removal to a special hospital for the insane are of paramount importance in nearly all acute psychoses. There are very few acute cases that cannot be more successfully treated in suitable special hospitals than in their own homes. Early diagnosis, if it mean anything, means the diffusion of a practical knowledge of psychiatry among general practitioners. Now this object can be attained only through the establishment of psychiatric clinics in all of our larger cities, and especially in connection with medical schools. Clinical instruction in insanity is given as yet in but few of our medical colleges, and even where it now forms a part of the curriculum, it is given in a perfunctory way, the chair of psychiatry being generally combined with that of neurology, rather to the neglect of the former. Speedy removal to a special hospital necessitates ease of access, the least possible legal interference, and location in the centers of population. In fact the same laws which govern the selection of sites for general hospitals are as appropriate for individuals sick from brain disease as for those sick from lung, liver or any other disease. Indeed, why are they not more appropriate, if the relative importance of the diseased organ to life and happiness be considered? We should never dream of placing a general hospital for acute disorders in some remote region of the country. Why deal differently with acute disorders of the brain?

PSYCHOPATHIC HOSPITALS.

Furthermore, one center of population in the commonwealth is no more entitled to benefit from the public treasury than another, so that the logical conclusion is that within the limits of each city of 50,000 to 100,000 inhabitants, there should be created by the State a special hospital for the reception and treatment of acute cases of insanity. Possibly isolated pavilions in connection with general hospitals might suffice for the needs of the smaller cities. Such hospitals for acute psychoses may be known as hospitals for nervous diseases, hospitals for mental diseases, hospitals for nervous and mental diseases, or, more briefly, following a recent suggestion, as psychiatric clinics or psychopathic hospitals. But the matter is of greater moment than the name. Since the acutely insane are ordinarily restricted, much as general hospital patients are, to their beds, wards or rooms, location in the midst of a city is no greater disadvantage to the special than to the general hospital.

The law should be as lenient to this afflicted class of patients as is compatible with due regard to the preservation of their personal rights, never however for a moment forgetting that after all it is a sick man and not a delinquent with whom it has to deal. In the framing of laws for the commitment of the insane, delinquency has often quite eclipsed illness in the eyes of legislators. For our psychopathic hospitals, doubtless some emergency provision of ten days or more would be permitted before resorting to commitment by any legal process.

It seems to me then that the true method of dealing with the acutely insane consists in the creation of these special hospitals in all of our large cities. The more one examines the matter, the more convinced one becomes of the feasibility, economy, reasonableness and humanity of such a course. It is the logical deduction from your axiom above referred to—early diagnosis and speedy removal to a hospital for the insane—and I venture to prophesy that before twenty years of our new century have passed, there will be psychopathic hospitals in many of our American cities, where now there exists not a single one. With the organization of such psychiatric centers, certain other important results will be attained. The profession as a whole will become

more interested in and more familiar with the psychoses, owing to better facilities for study and observation. The chair of psychiatry in our medical colleges will become distinct from that of neurology. The city psychopathic hospital will gather to it all those spirits that are eager for discovery in the wide domains of physiology, psychology, pathology and chemistry in their relation to the central nervous system, for it is in the cities that most of these pathfinders reside, and only in the cities that collective investigations by various laboratories become possible. Attached to the hospital for mental disorders in order to supplement the methodical clinical studies there made, there will be a variety of laboratories wherein the biologic unit of man may be studied by an aggregation of specialists trained in many branches of scientific work. Only in this wise will great discoveries and far-reaching results become attainable. There are good psychological laboratories now connected with a number of our universities, an outcome of the lively interest taken in recent years in the comparatively new field of physiological psychology; but their true sphere of usefulness and activity lies in combination with clinics and hospitals for nervous and mental disease.

The State of New York inspired by one of our well-known neuro-pathologists, Dr. Ira Van Gieson, has organized an ideal laboratory for the collective investigation of disorders of the central nervous system, ideal, I say, for it is the first time in the history of this hemisphere that a government has set to work to study insanity as it should be studied, viz., by an aggregation of discoverers in many fields, biology, anthropology, psychology, pathology, chemistry and the like. This is an event in our civilization. It is an example to be followed by other States and countries. Somewhat similar foundations have been laid elsewhere, but never so well nor so thoroughly. This good work should go on. Let money be lavished upon investigation of this kind! In no other way can it be better spent. The next step, in order to perfect so valuable an organization, should be the establishment of the necessary adjunct to this State laboratory—a psychopathic hospital—to the end that the clinical part of the great work may be closely combined with the more precise methods of scientific research. When this is accomplished, as it is quite sure to be, there will exist a model psychiatric institution for

many another large city to copy. Thus in the early years of the new century we shall expect to see created in conjunction with hospitals for the acutely insane in our cities, a constellation of laboratories, in which various experts will co-operate to achieve results almost impossible under present conditions.

Not the least valuable feature of the psychopathic hospital with its laboratory annexes, will be an outdoor department or dispensary, to which will come not inconsiderable numbers of patients on the border-line of insanity, for still earlier treatment than the city insane hospital affords. Preventive medicine as regards disorders of the brain has never had such opportunity as will here be given to test the value of its methods.

COLONIES FOR THE INSANE.

To return now to the hypothetical commonwealth for which we are to indicate ideal methods of caring for the insane, the class of acute psychoses having been disposed of, there yet remain the gradually increasing aggregations of chronic insane for which much greater provision must be made. Here it is no longer a question of early diagnosis and speedy removal to hospital, but one of humane care and economical administration. A considerable proportion of the chronic insane ultimately recover, either completely or with some defect, and another considerable proportion are acutely sensitive still to the pleasant or distressing stimuli of their environment, so that the phrase "humane care" includes medical supervision and treatment as well as some degree of homelike and agreeable surroundings. Healthful out-of-door physical employment has long been proved to be the best medicine for the chronic insane, not to speak of its value from the economical standpoint. Hence the chronic insane should be transferred from the psychopathic hospitals to the country. The old rule of "ease of access" has still some application here. The chronic insane should be located likewise in the vicinity of the large centers of population, both to admit of expeditious transfer and to grant both patients and friends the boon of frequent visits. There will be among these chronic insane some who, for various illnesses or surgical conditions, will have need of hospital treatment, so that a small general hospital will be a requisite in this

country institution. Others again, from the nature of their malady, will be more or less helpless, infirm, bed-ridden, excitable, unclean, and for these a small infirmary will prove necessary. The majority of the patients will be able to occupy themselves a part or all of the time, and need therefore neither the solicitous care of the hospital nor the restraint of the infirmary. This is the class which has occupied the attention of asylum physicians for years past the world over and much has been written concerning the best methods of caring for them, whether by boarding-out systems, county asylums, or by some such scheme as is exemplified at Gheel. In the ideal institution for the hypothetical commonwealth these working classes will reside in buildings adjacent to the scene of their labors. I take it that out-of-door employment being not only the most healthful but the most lucrative, the agricultural and gardening features will occupy the largest number of patients. Hence such as have to do with the live-stock, dairy, etc., will reside in the farmstead group of buildings. The tillers of the soil will have their own cottages near the fields and meadows, the gardeners theirs hardby the market-garden and flower-fields. The brickmakers and quarrymen will live in still different quarters, the artisans of the various handicrafts in still others, and so on, until we have before us not an "institution" after all, not a corridored agglomeration of huge pavilions, not a palatial barrack for hundreds of patients of all classes, but a farming hamlet, a village community if you please, in fact, the colony system of care in its best exemplification. These working classes among the insane, while they are too defective in mind to admit of return to their former positions in social life, are still to a marked degree sensitive to their environment, appreciative of most things that make life precious to their unrestrained friends in the outside world. You recognize this fact in all that you do for them, in your asylums or hospitals as now constituted, in your ornamentation of wards, halls and rooms, in your granting of parole of the grounds, in your supplying them with work, in your various entertainments, theatricals, balls, out-of-door games, musicals, and the like. Most of them require only a little care-taking, a little discipline, a little supervision, and they conduct themselves nearly as well as their saner brethren. Many of them recover even after years of chronic insanity. But for the majority

who do not recover, this community must be a permanent asylum, a refuge, a home. That word "home" has a significant meaning, and I cannot forbear dwelling upon it a little longer because of its significance. We need not go back to the ultimate origin of the idea of home, except to say that the instinctive love of home is deep-rooted in the breast of man, like the homing instinct of the pigeon and the dog, that it lies at the basis of family life and of state life, and of patriotism, and that in love of home some philosophers trace even the origin of the earliest beliefs in after life in another world. We need not go back as far as this, I say, in order to demonstrate the power of the instinctive love of home, or to understand why we should seek to give to our institutions for the unfortunate some homelike semblance; for we are confronted in our large cities with illustrations of that feeling almost every day. Many such illustrations occur to me, but I might cite the following excerpt from a newspaper which will serve my purpose as well as any. I chanced upon it the other day in re-reading "Sesame and Lilies." Ruskin quoted it as an argument in arraigning the English for despising compassion, but I copy it in abbreviated form merely to show how dear the home may be, even though every comfort be wanting:

"An inquiry was held on Friday by Mr. Richards, deputy-coroner, at the White Horse Tavern, Christ Church, Spitalfields, respecting the death of Michael Collins, aged fifty-eight years. Mary Collins, his wife, a miserable-looking woman, said her husband was a 'translator' of old boots. She went about and bought old boots which her deceased husband and son made into good ones and resold at shops for very little. Deceased and his son worked night and day to get a little bread and tea and pay for the room, 2 shillings a week, so as to keep the home together. On Friday night deceased got up from his bench and began to shiver. He threw down the boots saying, 'Somebody else must finish them when I am gone, for I can do no more.' There was no fire and he said, 'I would be better if I was warm.' The witness then took two pairs of the boots to sell at a shop, but got only 14 pence for the two pairs. With these 14 pence she bought a little coal and some tea and bread, while her son sat up the rest of the night working on boots to get more money, but the father died in the morning. The family never had enough to eat. The

coroner said, 'It seems to me deplorable that you did not go into the workhouse.' Witness answered, 'We wanted the comforts of our little home.'

"A juror asked what the comforts were, for he saw only a little straw in the corner of the room, the windows of which were broken.

"The witness began to cry and said that they had a quilt and other little things."

Now I should be the last to indulge in over-sentimentality in the arrangement and management of our charitable institutions, but it seems to me that an instinct so deeply engrafted in human nature is entitled to profound respect and consideration. The assembling of numbers of patients in large dormitory buildings, wards and pavilions, is more destructive of the home-feeling than anything else, and our attempts at decoration and furnishing detract little from the comfortless atmosphere. In institutions for children, in prisons and reformatories, and in general hospitals, we have a wholly different status of the inmates to deal with, and with them large numbers under one roof are not so objectionable. The chronic insane, on the other hand, are neither children in whom the home-instinct is small, nor so ill that this instinct is diminished or absent, nor are they delinquents in duress for punishment. The essential feature then of the agricultural colony for the chronic insane is separation into small family groups, the construction of cottage homes scattered among the various centers of industry. Methods of lighting and steam-heating from central plants have now become so successful that the old economical arguments against a true cottage system of care have less weight than formerly. The distribution of food supplies in a colony of this kind, where the provender in the main is of the simplest description and chiefly home-products, presents little difficulty, comparing favorably in cost with more elaborate methods of food distribution by means of underground corridors, food-cars, lifts, etc., which are necessary in our large mixed asylums, where all classes of the insane, the acute, the bed-ridden, the infirm, the chronic and the able-bodied are mingled together.

It is in the matter of the immediate care-takers, the attendants, that most patients find their greatest grievance. It is not strange that the vocation of attendant should present few charms,

and that young men and women seeking a livelihood as a rule prefer to follow almost any other calling than this. It does not attract the best classes. At one time it was thought that increase of wages would improve their quality, but it is doubtful if such increase as has been made has worked any great change. The general establishment of training schools for nurses or attendants in asylums has marked one phase of progress in recent years, and this has without doubt raised the standard of efficiency in certain respects, but the training which would avail the most, viz., training in ethics, is still a problem awaiting solution. Some countries are more favored than others in being able to secure the services of men and women with ethical training in the capacity of care-takers for the insane. I allude to certain religious bodies, such as deacons and deaconesses, in which vocations are chosen with motives and standards of a high order. Perhaps the time may come when the mass of attendants now with us may at least be leavened by the introduction of a few of these in each psychopathic hospital and colony. I have often thought that work among the insane would afford excellent practical training in patience, benevolence, tolerance and self-control for struggling divinity students.

ARCHITECTURE AND LANDSCAPE GARDENING.

We have never been deficient in our sense of fitness when selecting the sites for our great hospitals for the insane. Nowhere in the world are there more beautiful environments than have been chosen for these great public foundations. And we may well pride ourselves on the instinct that has guided us in this selection, that instinctive love of the beautiful in nature, the pleasing prospect, the agreeable "view," which no sordid motive has obscured or made us forego. In the matter of architecture, however, we have often been at the mercy of mediocre architects and of politics, or have been influenced by inordinate demands for magnificence on the part of communities in which asylums were to be located. I had frequently pondered over the origin of the prevailing styles of asylum architecture in this and other countries, the character of which was once described by the late Dr. Godding, if I remember rightly, as the "cathedral" style of architecture, until an asylum superintendent enlight-

ened me. He told me that in the ages when the insane were as yet in jails and prisons, and when physicians first awoke to the necessity of a different method of care and treatment, the patients were in the beginning transferred to abandoned cloisters and monasteries, and that these structures consequently became the type upon which the new asylums built in later years were modeled, both in Great Britain and upon the Continent. Modifications naturally came with time, but it is still easy to trace the evidence of such origin and to prove the truth of the assertion. Just as in the evolution of plants and animals we observe the effects of modification from century to century, the types remaining much the same, so in the evolution of the asylum, we see the gradual changes brought about by time and circumstance. We have unconsciously followed a distinct line of evolution, commonly making use of some existing prototype as a model, seldom breaking away freely from standards already established. Thus too frequently has the natural beauty of the landscape environment been marred and sacrificed.

In the designing of public buildings of whatever description, for whatever purpose, we should keep before us ever a certain ideal, a certain duty. We have a public duty to perform, not only for the benefit of the present generation, but for posterity. Our public architecture should express our highest ideals of what is beautiful in this art, should be an inspiration, a delight, a source of education, to the thousands who look upon it now and who will hereafter look upon it in centuries to come. True beauty in architecture does not lie in ostentatious display of domes and minarets and towers, but in the simplest adaptation of means to an end. Simplicity and temperance have more than once been stated to be the true principles of construction, and buildings reared on these principles are far less costly than many of the ornate but ugly structures we have raised. A great English critic[1] said years ago:

"You cannot command grandeur by size till you can command grace in minuteness; and least of all, remember, will you so command it to-day, when magnitude has become the chief exponent of folly and misery, co-ordinate in the fraternal enormi-

[1] Ruskin: The Crown of Wild Olive.

ties of the factory and poorhouse, the barracks and hospital. And the final law in this matter is, that if you require edifices only for the grace and health of mankind, and build them without pretense and without chicanery, they will be sublime on a modest scale, and lovely with little decoration."

As in the construction of our buildings on these lines of simplicity and temperance, so too in the landscape design must we show our regard for the same principles, seeking ever that beauty which comes from harmonious adjustment of buildings to the environment.

Bacon begins his essay on gardens with these words:

"God Almightie first Planted a Garden. And, indeed, it is the Purest of Humane pleasures. It is the Greatest Refreshment to the Spirits of Man; Without which, Buildings and Palaces are but Grosse Handy-works: And a Man shall ever see, that when Ages grow to Civility and Elegancie, Men come to Build Stately, sooner than to Garden finely: As if Gardening were the Greater Perfection."

That there is a gradual awakening everywhere to the importance of beautifying public structures and grounds is shown by the attention now paid to matters of this kind in many of our cities, and it was to me a source of much gratification to read not long since in the *Review of Reviews* of the extension of this idea of beautifying to even such prosaic objects as factories and factory homes. A manufacturer should be nothing if not practical, and yet this factory owner of Dayton, Ohio, employed one of the greatest landscape architects in America to draw up a design for the transformation of his barn-like buildings and the adjacent desolate quarters of the operatives from what was once called a "penitentiary" to what is now designated as a "paradise." But the capitalist was more practical than his commercial critics at first divined, for there has been a decided increase in the value of his property, and the factory street has been pronounced "one of the most beautiful streets in the country, when the value of the lots and the size of the houses are taken into consideration."

Thus we see, as far as the practical problems in the care of the insane are concerned, we are to-day confronted with a tendency to the establishment of psychopathic hospitals for acute cases in our cities and colonies for the chronic insane in the neighborhood

of centers of population. And in the upbuilding of this ideal class of institutions for the commonwealth or State, we are not to lose sight of the scientific side of our work, nor of the humane side in making the colony a homelike community with a better class of care-takers, nor of the art side in securing the best architect and the best landscape-architect that the country affords. I say "a tendency to the establishment of psychopathic hospitals and colonies," for I am sure I read the signs of the times aright, and that the drift of asylum evolution is in this direction. There are all over the world sporadic indications that point this way. Both the psychopathic hospital and the colony have already long passed the experimental stage, and I have myself seen them both in successful operation. There have been Psychiatric Clinics, or, as I here call them for want of a better term, "psychopathic hospitals" in a number of German cities for many years. Indeed there is only one university town in Germany now without one. They were in existence during my student days in Strasburg, Leipzig and Vienna. Since then many others have been founded, and I have just read a volume of 120 pages on the newest of them all, the Psychiatrische Klinik at Giessen.[3] This hospital was opened for patients in February, 1896, and was created quite closely upon the ideal plan of a clinical institute for the insane as outlined by Griesinger over thirty years ago. It is in the town of Giessen, near the other hospitals used for teaching purposes, adjacent to the pathological institute, and consists of ten or eleven cottages for 116 patients in a beautiful garden. The central building contains pathological, chemical, microscopical, photographic and psychophysical laboratories, besides a mechanical workshop, clinical auditorium, library, and a dispensary or polyclinic for outdoor patients. The necessary administrative offices and rooms for the director and assistant physicians are also here. There are cottages for private cases, and for quiet, suicidal, restless, and disturbed patients of each sex. This is probably the most complete hospital of its kind in existence at the present time.

The colony system of care for the chronic insane has also long passed its period of trial. "A satisfactory experiment on a large

[3] Published by S. Karger. Berlin, 1899.

scale was first made with a colony at Einum near Hildesheim in 1864; another was made in 1868 at Zschadras, near Colditz. Nowadays most asylums in Germany are connected with rural colonies."[4]

The best example of a colony for the insane is however that of Alt-Scherbitz, near Leipzig, which I visited twelve years ago and described in an article on "Some European Asylums" in the AMERICAN JOURNAL OF INSANITY for that year (1887). The following brief extracts from that article will give an idea of its character:

"A few miles from Leipzig is the asylum of Alt-Scherbitz, which to me seems in the van of all on the cottage or village plan. It is a newer, cleaner, more modern and more perfect Gheel. . . . The freedom of the patients is very great, and there is no depressing aspect about the colony at all, nothing to constantly remind outsiders and insiders of the usual coercive nature of such institutions. All of the villas for both men and women and all of the dormitories connected with the dairy, the laundry, the kitchen, the workshops, and all of the houses of the little farming hamlet, have unlocked doors and unguarded windows. There are no bars on any windows in the whole establishment. . . . . On the day of my visit there were 530 patients."

Now hear what is said by the latest authority on insanity and the care of the insane on the colony system. I quote from the 6th edition of Kraepelin, 1899:

"It is now sought everywhere to give the exterior of asylums by the segregation of patients in separate homelike villas, rather the appearance of hamlets for workingmen than prisons for the insane" (p. 359).

"The construction of asylums has experienced extraordinary progress of late years by the evolution of so-called colonies, in which the patients are as far as possible given liberty and occupation in country pursuits."

"The whole question of the care of the insane for a long time has probably found its solution in this best and relatively cheapest method of support. The first trial of this style of institution, carried out on a large scale to a surprisingly successful issue, and

[4] H. Laehr in Tuke's Psych. Dict., vol. i, page 546.

already imitated by many others, was that made at Alt-Scherbitz in Saxony by Köppe, where the entire work of the colony is done by insane workers."

"I have myself had opportunity to see patients, who had lived for years in a large closed asylum, improve in the most extraordinary manner, under the influence of the freer movement and more independent occupation of colony life."

Thus Kraepelin, and even here in our own country, if we note the changes that have taken place in our institutions for the insane in recent years, we shall observe that slow but sure evolution into the ideal methods here described—the great asylums throwing off here and there separate pavilions or cottages or sometimes even a sort of colony—a gradual disintegration of these massive cloister-like abodes into smaller and more prepossessing units—the opening of the doors which were once always locked for considerable numbers of the inmates—the multiplication of opportunities for employment out of doors. These are the indices that point the way, and it behooves us therefore to augur from these signs the direction we must take, and to hasten rather than hinder this irresistible advance toward psychopathic hospitals for our city, and colonies for our country institutions.

THE SCIENTIFIC PROBLEMS.

We have now considered the practical problems of caring for the insane. They are the ever-present, ever-important problems of to-day and possibly of centuries of to-morrows, for they deal with the welfare and happiness of—shall we say millions?—of insane either now in your charge or to be in your charge before the need for asylums shall have passed away. The scientific problems are fundamentally of higher import, for they deal with the prevention and cure of insanity as well as with the expansion of human knowledge in regions pertaining to the most wonderful of all natural phenomena, the manifestations of mind, spirit, soul. The practical problems are the emergencies of the hour, the scientific, the heritage we bequeath to posterity.

PREVENTION.

Surely we are not sufficiently engrossed with the problem of prevention, we do not sufficiently study and expound the doc-

trines of heredity, the evils of intemperance, the proper methods of care and education of eccentric and defective children, and the perils of marriage into neurotic families, in order that all men may grow familiar with these matters and be guided by the light of reason. The interchangeability of the neuroses and psychoses (epilepsy, chorea, hysteria, neurasthenia, migraine, somnambulism, dipsomania, criminal tendencies, eccentricities of character, insanity) from one generation to another, hereditary equivalents as they are called, indices of unstable nervous organization, should become matters of common knowledge to all mankind. The family physician, nay, the parents themselves, should be the first to recognize unstable nervous systems in peculiar children and prescribe for them the inexorable laws of prophylaxis, which may be briefly summed up as follows:

1. Cultivate the body of the growing child, by careful diet, regular hours, out-of-door life and efficient systems of exercise.

2. Train his muscles, rather than his mind, give him manual training rather than lessons during the years of childhood, youth and adolescence.

3. Forbid him all nerve stimulants, such as tea, coffee, wine, beer, tobacco.

4. Shield him from the dangers incident to puberty.

5. Develop the resistance of his organism to all external stimuli, hardening his body by the daily cold bath, frictions, exercise, hard bed and cold sleeping room; and teach him courage in the endurance of pain and mental stress.

6. Choose an occupation for his later years which shall invigorate his body, work for his muscles rather than for his intellect, an out-of-door rather than an in-door calling, country rather than city life.

Not the least of the benefits that shall accrue to us from the establishment of psychopathic clinics and hospitals will be the diffusion of a knowledge of insanity, its etiology and prevention, among all classes of physicians, and through them this knowledge will permeate our whole society. Then the lawyers and the doctors must put their heads together to devise means to prevent what the passion and folly of mankind, even in the light of better knowledge, may fail to restrain—indiscriminate marriage. Truly it is an overwhelming evil that the law allows a marriage such as came to my knowledge recently—that of an epileptic man with

an epileptic woman—here in New York, one of the supposed centers of civilization! Who can measure the possible misery or count the possible cost to society of such a union? We need but read a single story, that of the Jukes family, to shudder at the heritage of woe and disease that may go down the line of years. Think you these two epileptics were born in poverty and ignorance? Alas, one was a physician, the other the daughter of a physician! A mésalliance such as this is fortunately rare, but for one such marriage there are a hundred only a degree less wanton and wretched. I allude to marriages in which one of the contracting parties is epileptic or has been epileptic, or has had an attack of insanity. If my own personal knowledge of the frequency of marriages of this kind is paralleled by the experience of other physicians, then the law should certainly take cognizance of the evil and afford a remedy.

And now as regards the cure of insanity, what have availed thus far the garnered facts of these recent years of patient investigation? Little, as yet, I fear. The time-worn question is still asked:

> "Canst thou not minister to a mind diseased,
> Pluck from the memory a rooted sorrow,
> Raze out the written troubles of the brain?"

We have discovered certainly a specific for one form of insanity—that associated with myxœdema. Beyond that brilliant achievement we can boast of little gained in the way of actual remedies. Our palliative therapeutic methods are perhaps better than they were twenty years ago; yet, though we have gone apparently but a little step toward our ultimate goal, the discovery of the cause and cure of insanity, the step appears little only in comparison with the distance yet to travel; viewed by itself it is a wonderful stride. New vistas have opened, and a hundred trained workers now swarm these new paths, where formerly there was but one. I remember that not very many years ago there was a single pathologist, and he an unskilled one, connected with just one of the hundred and more asylums in this country. Now, a pathologist alone working in these wide fields would feel solitary and inadequate indeed; for his own road is a narrow one, and the specialists in anatomy, histology, cytology, physiology, chemistry, embryology, ethnology, psychology, psychiatry, criminology, anthropology, and the comparative departments of these

sciences, must all work together upon the whole man as a biological unit in order to accomplish our purpose. The other day I looked over a bibliography of the cytology of the nerve cell—a new and relatively small region of science—and counted some four hundred articles and books by two hundred and eighty different authors, contributed to the elucidation of nerve cytology alone, while the average output of articles and books relating to neuropathology and psychiatry is stated to number now something over thirty-five hundred per year. These figures are enormous, and yet, as I say, the good accomplished thereby seems infinitesimal in comparison with the colossal work to be done before the seats and causes of nervous and mental diseases shall be determined and the cures discovered. Small is the distance traveled, viewed in this light, and yet the goal draws ever nearer. Each year witnesses some new fact gathered, some new problem solved, some new hypothesis advanced, some new line of study indicated. It is not alone the pathology and therapeutics of insanity we seek to perfect, but there are marvelous riddles in the domain of the normal mind which we are striving to solve. Nearly the whole of our present knowledge of the workings of the normal body and brain has been won by the physician in his dealings with the organism when its functions were perverted or destroyed by disease. The psychologist therefore will make little progress in his laboratories as now operated in conjunction with several of our great universities, for his work therein must lie almost wholly with the normal mind. Such well-equipped psychological laboratories should be associated with clinics for nervous and mental disease, if their directors hope to accomplish much in the way of psychic discovery.

Now, each of us can do something to hasten progress in every direction suggested in the foregoing paragraphs. None of us is too busy to lend a hand or voice; we may not, through pressure and multiplicity of affairs, ourselves be able to delve deeply in scientific investigations, for indeed we need to be invincible athletes to master the product of the laboratories for a single year. But we may easily follow and favor the trend of human progress as it relates to our special work. We may speak and write in many places of the need of chairs of psychiatry in every medical school; we may demand the establishment of such professorships and the foundation of psychiatric clinics in conjunction with them.

We may behold and acknowledge the drift of the times toward the evolution of the psychopathic hospital in the city and the colony for the insane in the country. We may use our voices and our pens to urge the creation of laboratories in connection with these. We may inspire and direct the young men working with us to take up various lines of clinical and scientific work. We may insist that none of our vast material go to waste. And there is one side of the subject of insanity that the practical alienist, the superintendent of the asylum, even though he be busied with the multiform duties of direction, necessarily becomes familiar with, and that is the clinical side. He can freshen his interest, find a new fascination, and directly benefit science by more careful clinical study and record of his cases, in the light of the most recent methods of psychology, as expounded in the Anglo-American, French and German schools, by such men as James, Ribot, Ziehen, Flechsig, Wernicke, Kirchoff and Kraepelin. I am sorry that there is so little time left me to dwell upon these particular problems of the alienist, but they would require in themselves the full scope of an annual address. There is yet another means by which science may be directly aided by those who have not the time for the patient and laborious search after facts. The facts which are gathered together by the unremitting toilers of the laboratories have little value until correlated and compared with the acquisitions of our past experience. As Buckle says, "real knowledge consists not in an acquaintance with facts, which only makes a pedant, but in the use of facts, which makes a philosopher." The country doctor is often superior to the general practitioner of our cities, not only because he must needs become more self-reliant, since he has no consultant to share his problem or responsibility, but because his long reflection upon the facts he observes helps to make of him a philosopher. He who finds a fact contributes to the treasury of human knowledge, but he who discovers a principle advances civilization. So it often happens that the man who reads well and thinks deeply may digest the material collected by laboratory plodders, and build up therefrom some practical truth, brilliant hypothesis or broad general principle. The light of the imagination may illumine horizons which lie beyond the vision of the ordinary observer, and the eye of the seer and philosopher discern truths unapprehended by "the man with the hoe."

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THE LEGAL VERSUS THE SCIENTIFIC TEST OF INSANITY IN CRIMINAL CASES.

By CARLOS F. MacDONALD, A. M., M. D.,

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The protection of life and property, so far as it can be effected by statutory enactment, requires that offenses against either one or the other, when proven, shall be visited with punishment, regardless of the social rank or station of the offender. But occasionally it happens that crimes against life and also against property are committed or attempted by persons suffering from mental disease or infirmity; and the law, in recognition of this fact, very properly provides that an accused person when brought to trial may plead irresponsibility on the ground of insanity or mental unsoundness. Such being the case, it becomes pertinent to examine the so-called legal tests of insanity as applied to criminal cases, in order to determine how far such tests accord with the facts of nature as interpreted by medical science. Aside from questions of responsibility for crime, the criminal law does not specially concern itself with the subject of mental disease.

In view of the fact that the right to plead insanity as an excuse for crime is recognized in the criminal code of every civilized State and country, it necessarily follows that, whenever this plea is offered in defense, the mental status of the defendant must be taken into account and the question of responsibility must be determined, either by the application of the so-called legal test or by means of competent medico-psychological testimony. The plea of insanity as an excuse for crime rests on the supposition or allegation that the accused is a victim of a form of disorder the existence of which, if established, renders him irresponsible for his acts. This being true, we may properly assume that, medically speaking, insanity and irresponsibility are so closely

allied that they are essentially convertible terms, and that whenever the existence of insanity is clearly established the question of responsibility is practically determined. Hence this question of responsibility for criminal acts is, strictly speaking, a medical one and it can only be determined—especially in complex and obscure cases—by those who are practically familiar with the symptoms of mental derangement.

On the other hand the law, as interpreted by the courts, holds that the question of responsibility is not to be settled by the mere *existence* of insanity, but by the *degree* or *extent* of its existence; and in their efforts to establish a legal test of this disease the courts have undertaken to draw an arbitrary line of demarcation between insanity and irresponsibility which is wholly at variance with nature as interpreted by medical science. I refer to the test, so-called, which is based upon a knowledge of right and wrong and the capacity to correctly judge of the nature and quality of the act committed, this being in substance the decision of the highest appellate court in the State of New York to-day.

In the case of The People against Flanagan (52 N. Y., 467), the Court of Appeals held that the test of responsibility is the capacity of the defendant to distinguish between right and wrong, at the time of and with respect to the act complained of; and that the law does not recognize a form of insanity in which the capacity of distinguishing right from wrong exists without the power of choosing between them. In other words, that an individual who possesses a knowledge of right and wrong must necessarily possess the power of choosing the right and resisting the wrong with reference to any particular course of action, and that such a man is legally sane and responsible no matter how far his mind may be unbalanced in other directions. It will be seen that this proposition, or, rather this legal dogma, is but a slight step in advance of that formulated by the English judges in 1843, in answer to the questions put to them by the House of Lords in connection with the celebrated case of McNaughton, who was acquitted of the crime of murder on the ground of insanity. In the language of these learned judges: "To establish a defense on the ground of insanity, it must be clearly proved that, at the time of committing the act, the accused was laboring under such a defect of reason, from disease of the mind, as not to know the

nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong."

From the time this dogma, this judge-made law, was promulgated down to the present day, our courts of criminal jurisdiction, with their traditional regard for precedent, have generally accepted it blindly and propounded it to juries, in almost identical language, for their guidance in reaching a verdict, notwithstanding the emphatic protest of medical science that such a test is in direct conflict with the known laws of nature, and hence unscientific and false in its application to the mentally unsound.

Mr. Speranza, of the New York bar, in a paper recently presented to the Society of Medical Jurisprudence, referring to the legal test of insanity, said: "Present methods are not scientific, for, although, in theory, the opinions of the highest court are binding on itself and on all lower tribunals, yet, by subtle distinction, a constant over-ruling takes place which destroys uniformity. Furthermore, the scientific method is reversed, inasmuch as our courts propound principles and fit the cases to them, so that the question is not whether the principle is right, but whether the case fits the principle. As Judge Holmes has recently said, 'An ideal system of law should draw its postulates and its legislative justification from science. As it now is, we depend upon tradition or vague sentiment, or the fact that we never thought of any other way of doing things, as our only warrant for rules which we can enforce with as much confidence as if they embodied a revealed wisdom.'"

Mr. Speranza went on to draw a comparison between the two sciences of law and medicine. Both should be curative in effect, he said, but, as a matter of fact, the law is not so at all. This he attributed to the fact that our criminal jurisprudence "looks rather to the past than to the present or future."

He continued: "It is conservative almost to the point of stagnation, but the judges who sit in our courts have intrenched themselves behind two ancient principles, which rise up like a Chinese wall against progress and reform. 'Law is the perfection of reason,' they gravely tell us, and 'the king, through his magistrates, can do no wrong.' Grant these premises and progress becomes an impossibility."

It should be said, however, that prior to the decision rendered

by the New York Court of Appeals in the Flanagan case, already referred to, certain of our judges, imbued with a more progressive spirit, had, in their rulings, recognized the fact that moral liberty to commit an act is not necessarily accompanied by rational appreciation of the nature and consequence of the act. In other words, that something more than a mere knowledge of right and wrong is requisite to constitute responsibility for crime; that, in order to render an accused person responsible, he must not only know the nature and quality of the act in question, and that it was wrong, but in addition he must possess the power to choose the right and avoid the wrong; that, indeed, as a prerequisite to responsibility for a crime there must exist the ability to avoid committing it. This is in accord with sound medical doctrine. Says Clouston: "Make a man's power of controlling his actions the test. With that view every medical man will agree."

In the case of The People against Stillman, tried in Rochester, N. Y., in 1877, Mr. Justice Dwight in his charge to the jury said: "According to the law of the State which governs you and me in our relations to this case, a man is accountable for the act which he performs, unless his insanity be of such a character as that by reason of a fixed disease of the mind, he is deprived either of consciousness of the act, or of the knowledge of the moral and legal quality and character of the act which he committed, or by some disease of his mental nature is deprived of the ordinary power of volition to will that which he knows to be right. That is the legal standard by which you are to be governed. Was his mind so far affected by fixed disease as that he was, at the time he committed the act, deprived either: first, of consciousness that he did the act, or: secondly, was deprived of the power to judge the moral and legal character of the act which he committed; was unable to judge that the act was morally wrong or that it was legally wrong, or that it subjected him to the penalty of the law, or: thirdly, was absolutely deprived by mental disease of the power to will and to do that which he knew to be right?"

The scientific ground here taken by Justice Dwight marks a decided advance in the jurisprudence of insanity, and one which tends to place it in closer harmony with the deductions of modern science. Again, in The People against Kleim, the court held that the accused in order to render him responsible, "must know

that the act was wrong and punishable, *and be able to compare and choose between doing it and not doing it.*"

"This," says Ordronaux, referring to Justice Dwight's charge, "is unquestionably sound doctrine, and it is accordingly most unfortunate that the Court of Appeals should have entirely overlooked it in their latest decision upon this point as given in Flanagan versus The People"—a decision which has summarily swept away the whole progress and "reverted us to legal tests of criminal responsibility, which courts in other States are everywhere discarding as unsound."[1] In fact, one needs but a superficial knowledge of mental disease to know that an abstract knowledge of right and wrong is not uncommon in many forms of insanity, other than idiocy or profound dementia.

We have, therefore, on the one hand, the contention of the legal profession, fortified by time and tradition and backed up by judicial decisions, that insanity is a question of law to be determined by the courts according to the form or degree in which it manifests itself; and that legal responsibility, in each instance, depends upon a knowledge of right and wrong as to the acts committed at the time said acts were committed; while, on the other hand, the medical profession holds that insanity, in its relation to crime, is always a question of fact to be determined by the aid of medical science, and that whenever its existence can be so determined, the fact should be sufficient to establish the irresponsibility of the accused, regardless of the form or degree in which his disease may manifest itself. In other words, medical science holds that the whole question of responsibility should rest upon the existence or non-existence of mental disease and not upon the presence or absence of a knowledge of right and wrong. This eminently sound doctrine has not only been affirmed by practical alienists in general, but has been attested by formal resolution of the British Association of Medical Officers of Hospitals for the Insane, in the following terms: "Resolved, That so much of the legal test of the mental condition of an alleged criminal lunatic as renders him a responsible agent because he knows the difference between right and wrong, is inconsistent with the fact well known to every member of this

[1] Judicial Aspects of Insanity.

meeting, that the power of distinguishing between right and wrong exists very frequently among those who are undoubtedly insane, and is often associated with dangerous and uncontrollable delusions."

The serious defect in the legal test of insanity, as established by the Court of Appeals in the State of New York, is that it undertakes to positively define the degree of mental unsoundness which shall absolve its victim from responsibility for his acts, an undertaking which every practical alienist knows is impossible; that is, it has undertaken to decide what the law of nature shall be, rather than what it is. "Jurists," says Ray, "who have been so anxious to obtain some definition of insanity which shall furnish a rule for the determination of responsibility, should understand that such a wish is chimerical from the very nature of things. Insanity is a disease, and, as is the case with all other diseases, the fact of its existence is never established by a single diagnostic symptom, no particular one of which is present in every case." The fact that it is impossible to formulate a strictly scientific definition of insanity, that is, a definition which shall embrace every variety of the disease and at the same time exclude certain conditions of mental disturbance or disorder which do not come within our conception of insanity, is in itself the strongest argument against the utility of any legal test of this disease. "And if a fact indefinable in itself, as insanity is conceded to be, is not reducible to a fact in law, then it is unfortunate that the courts should maintain a contest with science, and the laws of nature, upon a question of fact which is within the province of science and outside the domain of law."[1] That which in fact is a condition of mental disease cannot in law be a condition of mental health.

In the language of Judge Doe, in the case of The State against Pike, "If the tests of insanity are matters of law, the practice of allowing experts to testify what they are, should be discontinued; if they are matters of fact, the judge should no longer testify without being sworn as a witness and showing himself qualified to testify as an expert."

The French penal code declares that, "There can be no crime

[1] Judicial Aspects of Insanity. Ordronaux, p. 243.

nor offense if the accused was in a state of madness at the time of the act." The German penal code provides that, "An act is not punishable when the person at the time of doing it was in a state of unconsciousness, or of disease of mind, by which a free determination of the will was excluded."

Even in England the rule laid down by her Senate of Judges in the McNaughton case is no longer the sole guide in determining responsibility for crime, although so great was the weight of authority attached to this decision that it has taken years to overcome its prestige and to supplant it by legislative enactment more in harmony with the greater laws of nature, by which human actions are determined. The English Trial of Lunatics Act now provides that: "If it appears to the jury before whom such person is tried that he did the act or made the omission charged, but was insane as aforesaid at the time when he did or made the same, the jury shall return a special verdict to the effect that the accused was guilty of the act or omission charged against him but was insane as aforesaid at the time when he did the act or made the omission."

The revised Code of Criminal Procedure of the State of New York, Section 21, provides that: "A person is not excused from criminal liability as an idiot, imbecile, lunatic or insane person, except upon proof that, at the time of committing the alleged criminal act, he was laboring under such a defect of reason, as either—

1. Not to know the nature and quality of the act he was doing; or,

2. Not to know that the act was wrong.

It will be observed that the language of this statute is almost identical with that used by the English judges in respect to the McNaughton case in 1843, and reiterated by the New York Court of Appeals in its decision in the Flanagan case, a decision which the trial courts have generally regarded as having the force of law, and which is now embodied in the statute, with the implied approval of the legal profession.

Thus it appears that the lawmakers of the Empire State, following the dictum of her Court of Appeals, and ignoring the teachings of medical science, have undertaken to determine by statutory enactment what insanity is, and likewise to establish a

legal test whereby its presence may be demonstrated. In other words, with a wisdom superior to nature's, they have attempted to define the conditions of responsibility in mental disease by declaring in law what shall be, rather than what is, and in so doing have given us a test which is based on a misconception of the true nature of insanity, which has been handed down from generation to generation and which is so narrow in spirit and so untenable in reason that every experienced alienist must regard it as artificial, arbitrary and fraught with danger to humanity and the ends of justice. To base the diagnosis of insanity upon a question of the knowledge of right and wrong, that being in effect what this so-called test requires, is directly in conflict with a well-established fact in medical science as well as a serious menace to human rights and individual liberty.

Now, if every form and every stage of mental disease were invariably attended by a loss or suspension of the knowledge of right and wrong, such as usually occurs in extreme types of mania, melancholia, paresis and dementia—forms or stages of the disease which are usually characterized by mental aberrations so marked as to bring them easily within the ken of the unskilled observer, who could readily recognize them as symptoms which in themselves furnish presumptive evidence of the absence of power to *rationally* distinguish between right and wrong, no valid objection could be raised to the present legal test of insanity, wrong in principle though it be, for the reason that its practical effect, as applied to the class of cases referred to, would be to establish irresponsibility in substantially every instance, regardless of the nature of the act committed, thus securing the ends of justice. Unfortunately, however, only a small percentage of the insane, which come within the jurisdiction of our criminal courts, belong to the types of insanity above specified, for the reason that, as a rule, this class of insane persons are not homicidal and consequently seldom commit or attempt to commit homicide, or what is technically known as crime against the person. That is to say, they do not belong to the class of insane who are known to be dangerous. As already intimated, practically there is little or no difficulty in determining the question of responsibility in cases of this kind when charged with crime, for the reason that they readily fall within the legal conception and definition of mental disease. It

is in a widely different and much more frequently represented form of disease among the so-called criminal insane—insane persons charged with crime—that the application of the legal test of responsibility has proven so unsatisfactory, namely, the "dangerous insane," a large proportion of whom are paranoiacs, or, in other words, victims of systematized delusional insanity which older writers were wont to call monomania, "reasoning mania," or partial insanity. The obscure and doubtful cases that so frequently puzzle our courts of criminal jurisdiction are drawn almost wholly from the ranks of this now well-understood form of mental disorder. Many of the victims of this form of insanity, contrary to popular belief, but as every experienced alienist knows, possess a perfectly clear knowledge of right and wrong in the abstract and also comprehend, abstractly, the nature and legal consequences of acts similar to those which they have committed. Paranoiacs also are frequently actuated by most powerful motives in the commission of crime, motives similar in character to those which frequently govern sane persons, namely, revenge, vindication of personal honor, self-defense of life or property, etc., but if we seek for the foundation of these motives we shall find that, unlike the motives of the sane individual, they are not founded on reality, but are the offspring of a diseased or disordered intellect, a psychopathic state, which has deranged the psychical apparatus, so to speak, and left it awry, even though the logical apparatus remains intact. Owing to the obscuration of his mental horizon by this psychopathy, the paranoiac is rendered incapable of completely and harmoniously exercising those physiological functions of the brain, which are denominated the intellect, the emotions and the will. He is prone to premise falsely, and to morbidly misinterpret the conduct, the attitude and the motives of those about him, and while he may, and often does, reason logically, he reasons from wrong premises and in a way that a sane man would not do. "The delusions," says Régis, "are connected, coherent, lifelike, starting from false or misinterpreted data, but eminently logical in their deductions."

It matters little, therefore, whether we admit with Wernicke and others, that the paranoiac has no defect of intelligence and that his mental weakness is only apparent, not real, or accept the view of Hitzig, that "he does not possess his full mental capital

and suffers from a defect of intelligence," all must agree that the effect of his disease upon his mental capacity is such as to render him incapable of exercising his reason and will-power as he would do were he in his normal mental state; and that consequently he should be regarded as neither morally nor legally responsible for his acts. "The true test of irresponsibility," says Forbes Winslow, "should be, not whether the party accused was aware of the criminality of his actions, but whether he has lost all power of control over his actions."

To set up a legal test or standard of insanity which is not in harmony with the teachings of medical science, and at the same time so narrow in scope as to exclude from its benefits the victims of paranoia, who represent such a large proportion of the dangerous insane, simply because they possess a knowledge of right and wrong, is a disgrace to jurisprudence and a travesty upon justice.

The real question of fact for the jury to determine in cases of alleged insanity in criminal trials would seem to be the following:

1. Did the defendant at the time of the alleged crime have sufficient mental capacity to *rationally* appreciate the nature and consequences of the act he was committing, and, if so, had he sufficient power of will to enable him to choose between doing or not doing it?

2. If he had lost the power of choosing with reference to the particular act, was the loss due to disease, and not to "heat of passion," intoxication or other self-induced temporary mental disturbance?

It must be admitted that a correct solution of these questions, involving as they do, human life and liberty, is of most vital importance; and inasmuch as they relate directly to disease, the facts upon which their solution must rest can properly be interpreted for the jury only by competent medical testimony. In other words, substantially the same kind of tests should be applied here as is now required by law for the commitment of an individual to a hospital for the insane, namely, an examination of the mental condition of the accused by physicians who are practically familiar with the phenomena of insanity. If this were done it is safe to predict that much of the discrepancy and conflict of opinion in our courts of law respecting the question of responsibility in criminal cases where insanity is alleged, would disappear.

THE CARE OF THE INSANE IN FARM DWELLINGS.

By G. ALDER BLUMER, M. D.,
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Fashion plays a large part in the practice of psychiatry everywhere. Just now our specialty, alleged by some of its detractors to have been slumbering these many years, is apparently wide awake to the promise and potency of laboratory work. The younger men especially are engaged on a hundred problems of research and their elders, although some of them are perhaps too old to take an active part in the correlation of sciences, discern with the eye of a quickened faith the substance of things not seen. It is distinctly the fashion—and I say it in approval, not in disparagement—to give to papers dealing strictly with the scientific aspect of our work the more cordial welcome, insomuch that one feels that apology is due to this distinguished body for bringing before it a subject so commonplace as the care of the insane in farm dwellings. Albeit the alienist who ministers to the whole insane man, as found by and large, is of necessity also a publicist, and certain practical considerations of care and guardianship may not be wholly set aside as unprofitable in gatherings of this kind. Hope as we may with all the hopefulness that the new science inspires; strive as we may, in our laboratories and in our wards, with all the might of young giants refreshed with new wine; go to the people as we may, with sanguine hearts and preach to them the gospel of prevention from the housetops, the fact, alas, that will not down and cannot be wisely blinked is that the symptom-complex to which we give the name insanity expresses in the main certain bodily conditions that are woefully chronic. Postulate so much and it is evident that those of us who are engaged in asylum work on a large scale are brought face to face, day by day, with the problem not solely how the individual patient shall be cured, but rather in what manner the welfare ot the mass shall be best subserved. Reduced to its simplest terms, that question

is how shall the average insane man's social condition be made to approximate, in safety and with the maximum of benefit to himself, that of his sane brother who is self-supporting and at large in the community? So far as material comforts are concerned, the lot of the insane man at the close of the nineteenth century is in tremendous contrast with that of the wretched madman of the earlier, darker days. Even the past twenty years have wrought a marked change in his condition. Non-restraint once adopted as a blessed principle of treatment, scales fell from eyes everywhere, tentative measures took the place of a timid reserve, the success of one experiment led to another, till to-day not only has our own conception of the insane man and his needs changed, but we have been able by constant object-lessons to modify the ignorant views of the people—views that were after all but the result of our own unenlightened care. It is uncommon, I hope, to find anywhere in the United States or Canada at this time a hospital for the insane that does not possess its open ward where patients go and come unhindered by lock and key or other conditions of custody, mechanical or human, that irk the soul. We have our farms and gardens to which the patient sallies forth each day as a contented laborer to his toil, our shops in which he sweats, though they are not sweat-shops, and for those whose condition precludes occupation there are well-appointed grounds with ample shade, while for the sick our hospital wards with trained nurses fulfil the indications for treatment. It would almost seem, indeed, that the *Ultima Thule* of asylum care had been reached. Let no man thus flatter himself. So long as the family is recognized with us, as in all civilized countries, as the unit of social life, so long must approximation to that ideal be the goal to which we should strive in our care of the chronic insane who are capable of appreciating its natural and greater attractions. This is of course no new theme. Gheel is an old story. Years ago Baron Mundy wrote fully and well in recognition of this social and humane principle, and later Dr. Lentz, describing the farm asylum, declared that the mechanical routine of these establishments could never supply the salutary result of natural life in the family, and predicted that this intermediate institution between the close-asylum and domestic freedom would end eventually in family care for all the insane who

could profit by it.[1] So far as Scotland is concerned this prediction has been largely fulfilled in the boarding out in families of twenty-three per cent. of the dependent insane, and we have it on the authority of Dr. J. A. Peeters, the presiding genius of Gheel, that to-day almost every European country is now either practising the Gheel method, or experimenting with it, or getting ready to introduce it. We all know what has been accomplished along these lines in Massachusetts. Mr. F. B. Sanborn planted family care with enthusiastic confidence in 1886, his successors in office have watered it with varying and fitful efficiency, and if the increase cannot now, after thirteen years, be characterized as God-given, the fault lies not with the system but in the watering-pot. Inquiry into the causes of the failure or small success of family care in Massachusetts would involve not only digression but a controversy which I prefer to avoid at this time. My purpose is rather to call attention in this paper to a little experiment of my own in central New York and to point an obvious moral. The success of farm colonies in this country and Europe had already been demonstrated even if the idea had fallen short of adequate development. Utica meanwhile had been concentrating her energies mainly upon the expansion of her industrial enterprises, farming on a large scale having played in her economy but a minor part. This policy was the forced incident of a meagre acreage—the penalty of a suburban situation and high prices for available land. Year after year appeal had been made to the legislature and later to the State Commission in Lunacy for money to buy adjoining or near-by farms. Weakening in its persistency by annual failure and despairing of loosening purse-strings to the width of purchase when hungry Manhattan's constant clamor for gold was rending the air, but still having an abiding faith in its cause, Utica was ready for a compromise of her own naming. She had taken a hint from the practice of a Japanese official, well known in comic opera, and given artistic verisimilitude to a bald and unconvincing narrative by means of figures so arrayed as to make it apparent that even if the scheme did not pay in human results it would not involve monetary loss and would furnish besides an additional capacity. Permission

[1] See F. B. Sanborn in Charities Review, 1899.

was thus obtained, after years of weary waiting, to lease for three years, with an option to purchase, a farm of 160 acres within a mile from the main building; rent, $100 per month; purchase price, $32,000. The details of this initial experiment I have ventured thus to give in order to encourage others in so far as our experience may show in what manner an unhappy central authority in supreme financial control, with one furtive eye on the legislature and the other on the taxpayers' money-bags, may be momentarily relieved from the unnatural tension of a disfiguring strabismus and enabled to see the needs of a hospital with clear, straight and normal vision. As an incentive to strenuous effort and a means of discipline it was perhaps best that the purchase was not made outright. The hospital was put alike on its mettle and on its honor. The farm had upon it an old frame dwelling capable, with some repairs, of accommodating twenty-three male patients. It had barns, such as they were. But it was a sorry affair on the whole, though obviously full of cheering possibilities. Here was taken, over two years ago, with a Godspeed from the State Commission in Lunacy, our first resolute step from the close-asylum to domestic freedom.

To knock out a partition here and there in the old-fashioned commodious farmhouse was the work of but a day or two. Odds and ends of old and discarded furniture, picked up in the hospital, seemed to have been foreordered for the new place. The barns were patched up to shelter horses, cows, pigs and poultry. Brightness followed the paint-brush. A young farmer and his wife, both having had previous experience with the insane, were readily found. And Graycroft sprang into life. Very soon we had there a happy colony of twenty-three patients leading a simple, natural farm life as different from that lived in the main building as possible. In selecting attendants to work with these patients the mistake of hiring men who had had previous asylum experience was carefully avoided. Two young men and a young woman of rural rearing and rural instincts entered the colony as workers. It helped matters to have one of the young men marry the young woman somewhat later. These hired people knew nothing of the unfarmer-like farming of the average asylum, had not been contaminated in any way by the enervating influences of a big establishment. They were up at cock-crow and abed

long before the urban attendant is wont to wend his way home from the city. Farmers and farmer patients seemed to juggle with the old farm, so quickly did the results of their steady labor appear. Roads were improved, good fences replaced bad ones, ditches were dug, fields were ploughed and cultivated, and, presto, the whole farm smiled back approval on its makers. And what of the patients themselves? They were nearly all chronic cases, it is true, but the improvement that occurred in their condition, physical and mental, exceeded the most sanguine expectation. The well-known institution look and manner began to disappear as the men responded promptly to the freer life and became bronzed by the sun. It was the life they had lived at home; the only life that to them was a natural one. Whether seen sweating in the fields in honest toil; nooning in the shade of the orchard; strolling hither and yon in unhampered freedom in the enjoyment of tobacco—a solace said once to be "next to that which comes from Heaven"; loitering about the kitchen or other places where, on a farm, "Sabean odors clog the air" and fill the soul with joy; eating with the relish of hungry men or sleeping the dreamless sleep of men who work—these colonists were manifestly better off than they had previously been in the more or less artificial life of the main building. Bye and bye ample crops furnished undeniable proof of the experiment on the economic side. Meanwhile a little adjoining farmsteading of seventeen acres on which was a modest cottage with an unfinished second story fell vacant. For $10 per month we leased it for three years, reserving an option to buy at $200 per acre. Here we soon made sleeping rooms for seventeen more men, adding a cheap lean-to with big open fireplace for day-room and a simple platform verandah with awnings for summer resting place. This became Cragside. It was near enough to Graycroft to make the maintenance of a separate kitchen unnecessary, but the capacity of the colony having thus been increased to forty, new dining-room accommodation was provided for that larger number at small expense. The following year a good farm-house, distant from Graycroft but a few hundred yards, with its twenty acres of contiguous land, was placed at the disposal of the hospital. The opportunity thus to colonize twenty more patients was too good to lose. This property was leased for three years at an annual rental of $450, with

an option to purchase for $12,000. This time able-bodied working women patients of the chronic class were quartered in the country home, and Dixhurst—so named for Miss Dorothea L. Dix, as Dr. Gray's memory had been respected in christening the men's colony—became an integral part of our hospital system.

The women reacted to their changed method of living precisely as had done the men. The idea in establishing this rural annex for women was not only that the colonists should live a family life and support themselves practically by their own industry, working, as some farmers' wives and daughters do elsewhere, in the lighter labor of field and garden, but it was thought that the domestic work of the men's colony could be more profitably done by women folk. The women selected had nearly all passed the climacteric, their average age being 53, with an average duration of asylum life of over six years, and the risk of sexual accidents had thus been reduced to a minimum. Two women oversee the operations of this colony with occasional male assistance from Graycroft in the performance of laborious work. Sparing you further detail as to the *res angustæ* of domestic life, I may be permitted a brief summary of the economic results of the rural settlement. Graycroft, Cragside and Dixhurst comprise together 200 acres, or, if a tract of forty acres of waste land bought last year to connect the State Hospital farm with the colonies be credited to the latter, 240 acres. The value of last year's crops, notwithstanding the exhausted condition of the land when the hospital took possession, may be safely put at $5000, if milk, eggs, poultry and pork be included in the estimate. The value of the patients' labor is difficult to compute, but figuring the average earning capacity of each able-bodied colonist at $10 per month, the total for forty men would not be less than $4800. Similarly, the cost of patients' maintenance cannot be given with absolute accuracy as compared with main-building prices, as supplies are issued from the general store to the colonies in about the same proportion. It is certain that the cost does not exceed the home rate and probable that it falls somewhat below. Seven employees at an average wage of $25 are chargeable to the three farms, a total of $2100 per annum. Last year, besides helping with ploughing, seeding and harvesting, the patients assisted in building six hundred rods of fence, laying over two miles of tile

drain and setting out six acres of fruits. In the winter they harvested the ice crop. Economically, then, the care of the insane in our farm dwellings may be claimed to have succeeded, but even if failure had attended the experiment on the economic side, that failure would have been amply offset by the human results of the experiment. Of the 92 male patients under treatment during two years the average duration of previous custody was 3½ years and their average age was 43½ years. Of the number discharged, thirteen had recovered and five had improved. In two years 29 cases were returned to the hospital for various reasons—attempts to escape, insubordination, recurring mental disturbance, sickness or injury, request. It is fair to add in parenthesis that it was in many cases more a matter of expediency than necessity to remove these patients to the main building where there is at no time a lack of ideal cases for colony life, and nearness makes the transfer easy. That only two patients were returned at their own request is a fact of great significance. It confirms the opinion of Sir Arthur Mitchell,[2] ex-Commissioner in Lunacy of Scotland, and the father of boarding-out in that country, that "going back to family life is a going back to true social pleasures and enjoyments. These are longed for by asylum inmates just in proportion to the power they have of longing for anything. No sane person would exchange them for asylum dances and concerts. The thousand and one familiar things constantly going on around patients in families constitute a far greater source of enjoyment than the scenic and got-up entertainments of asylums and fill their lives with truer delights." Reference has already been made to the experience of Scotland in boarding-out twenty-three per cent. of her dependent insane with guardians in private dwellings. This percentage would seem to be possible of attainment in New York. The male department of the Utica State Hospital has three open wards containing 95 patients, at Graycroft there are 40, a total of 135 male patients out of 544 who are adaptable to the freer life of the farm dwelling or its equivalent, in other words, over 24 per cent. of the total male

[2] The Insane in Private Dwellings in Massachusetts. By Sir Arthur Mitchell, K. C. B., M. D., LL. D., Boston Med. and Surg. Journal of November 4, 1897.

population. The statistics of Dixhurst for one year show the women's colony in an equally favorable light. It is clear that this system of family care—for that it is in essence—is susceptible of further development at Utica. Neither is it too much to say that, given a safe scheme of supervision with a State Hospital as basis of operation, all or almost all the patients now in the colonies I have attempted to describe might be suitably provided for in well-selected families in Oneida and other central New York counties. Our methods do not imply a peculiar quality of supervision or restraint that would not be available elsewhere among farmers of average intelligence and respectability. Yet there would seem to be a distinct advantage in having such homes for the insane bear a succursal relation to a central hospital, thus permitting, as occasion might require, the ready return of a patient, either temporarily or permanently, for special treatment or more stringent custody. That there are many farmers who would be willing to receive such patients in their homes for a reasonable compensation—lower perhaps than the price at which they are now maintained in the State Hospitals—I have no doubt. It may be remembered in this connection that in 1884, at the instance of the Board of Health, Lunacy and Charity of Massachusetts, Dr. H. R. Stedman made a valuable report on the Scotch system of family care with especial reference to its applicability to the insane poor of his State.[3] In considering objections to the system, he disposed of the *a priori* argument that the pride and social ambition of the American farmer would make him the unwilling host of an insane guest boarded for gain, by instancing the fact that *sane* dependents had long been placed out in families in Massachusetts and other States without any apparent compromise of the esteem which the receiving family had previously enjoyed in the community. This fanciful objection suggests the argument that some of us remember as a favorite years ago when it was alleged that there was in the universal Yankee some mysterious quality that rendered the adoption of non-restraint im-

[3] The Family System as an Accessory Provision for our Insane Poor. By Henry R. Stedman, M. D., in Sixth Annual Report of the Mass. Board of Health, Lunacy and Charity, 1884. See also, by the same author, The Family or Boarding-out System, Am. Jour. of Insanity, January, 1890.

practicable, because, forsooth, while his pride might permit mechanical restraint without protest his soul would rebel against the imposition of the restraining hands of his fellow. Why our farming class, being as it is an amalgam of all nations, should differ essentially in its attitude towards this question from that of agricultural Europe, I have never understood. Personal experience, alike in Scotland and the United States, inclines me to believe that the American farmer is just as keen to make a dollar, legitimately or otherwise, as is the canny Scot to earn his honest bawbee. Be this as it may, the significant fact stands forth boldly that in Massachusetts "the demand for insane boarders is always greater than the supply."[4]

This readiness on the part of the people to serve the commonwealth in a humane work appears to have grown in proportion as that other bugbear has dwindled, namely, the fear that homicide, suicide or other casualty would follow in the wake of the larger freedom of family life. The fact is that accidents are less frequent among the boarded-out insane than among a like number of patients in the close asylum. In further confirmation of Scottish claims, the fallacy that the removal of able-bodied patients to colonies cripples the available working force of the parent institution has been shown by the results of Utica experience. Hear what Sir Arthur Mitchell has to say on this subject:[5] "When such patients are removed this is what happens: it is found that there are other patients who can be induced to work. The set of good workers, being sufficient in number, no serious effort is made to lead non-workers to become workers. They are not wanted and a refusal to work is too easily accepted as a thing that cannot be got over."

Having thus all but occupied my allotted third of an hour—a limit that has precluded academic treatment of the subject, although in any event I could but have repeated a twice-told tale—permit me in conclusion earnestly to urge upon those who have not yet made the essay, not only the serious consideration of this great public question but the tentative solution of it by actual ex-

[4] Eighteenth Annual Report of the State Board of Lunacy and Charity, January, 1897.

[5] Boston Medical and Surgical Journal, *loc. cit.*

periment. Let each man answer for himself the pertinent question whether the State is justified in cooping up within the walls of a hospital for the insane—aye, even one with an open-door attachment of latest model—a chronic patient who can be as or even more cheaply, as or even more safely, as or even more comfortably, provided for under the simple natural conditions of domestic freedom to which your attention has been called and so kindly given. And finally I desire distinctly to disclaim novelty or priority—bugbears of self-conceit—for what has been accomplished as a stepping-stone to family care in the founding of the farm colonies of the Utica State Hospital, but rather to avow contritely a sense of shortcoming in not having perceived long ago the brilliant possibilities that the situation offered. Surprising and lamentable it is with what leaden feet a departure from the conventional order of things makes headway against obstacles real and imaginary that beset the path of destiny. How great the *vis inertiæ* to be overcome before an effective momentum is acquired! The colony at Gheel is so old as to have its origin shrouded in the mystery of miracle and superstition; for over forty years Scotland has been maintaining a growing percentage of her dependent insane in private dwellings till now 23 per cent. are thus happily cared for; it is fifteen years since Dr. Stedman made his report to the Massachusetts board; thirteen years since Mr. Sanborn, the valiant and tireless father and champion* of the system began to board-out the insane in New England; and, alas, here we are on the threshold of another century before we apprehend as a country what the thing really means.

Seht ihr den Mond dort stehen?
Er ist nur halb zu sehen
Und ist doch rund und schön.
So sind wohl manche Sachen
Die wir getrost belachen,
Weil unsere Augen sie nicht sehen.

* *Vide passim.*

THE NATURE AND PRINCIPLES OF PSYCHOLOGY.[1]

By BORIS SIDIS, M. A., Ph. D.,
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As I glance over the announcement of the many subjects to be brought before your attention and look at the long file of the names of lecturers, all with medical titles, I cannot help feeling grateful to you for the honor you have bestowed on me, a mere psychologist, by your kind invitation to read a paper on any subject in my line of work. Such an invitation is to me an event, a sign of radical changes going on in the undercurrent life of the medical world. Medical men and especially alienists seem to observe less strictly the law "not to admit an alien into the congregation of the Lord," and are willing to listen even to a psychologist.

Being under the delusion that to read a paper meant to lecture, I prepared a rather extensive series of lectures, "On the nature and principles of Psychology," and discovered but too late, that one was not allowed to tax your patience for more than twenty minutes. I was rather displeased at first, but after I thought the matter over, I came to the conclusion that the twenty-minutes' rule was a wise one, dictated, no doubt, by bitter experience.

Seeing that time is precious, I decided to read the introductory chapter only, and dismiss the rest in the same summary fashion as the biblical historian deals with the deeds or misdeeds of some scriptural Ahaziah or Jehoshaphat—it is all written in the book of Chronicles—in the present case—it is all to appear in the "Archives."

The paper is divided into six chapters:

The first chapter "Psychology and the Medical Profession," the one I am going to read to you is introductory in its nature.

[1] *Read at the American Medico-Psychological Association in New York, May 25, 1899.*

The second chapter treats of "The Scope of Psychology"; the third of "The Sources of Psychology"; the fourth of "The Chief Hypotheses of Psychology"; the fifth of "The Data and Postulates of Psychology"; the sixth of "The Theory of the Moment-Consciousness" in its relation to the phenomena of association, dissociation and their physiological correlative retraction and expansion with an account of psychopathological work done at this Institute and substantiating these theories.

And now as to the relation of Psychology to the children of Æsculapius.

Psychology and the Medical Profession.

Psychology and medical science were for centuries as far from each other as heaven from earth. Psychology was considered by the practical mind of the physician as ideal philosophical wisdom, which may be regarded with distant awe, but which cannot possibly be of any earthly use in the affairs of ordinary life. This relation can no longer be maintained. On the one hand the imperative necessity of treating insanity, and the investigation of abnormal mental life in general and the recent researches into the more complex nervous and mental troubles such as the different forms of aphasia and amnesia forced medical science into psychology, and on the other hand the growth of the scientific spirit, the development of physical and biological sciences forced psychology into the pathways of concrete sciences. Both have benefited by the change. Medicine from being a practical art regulated by the rule of thumb and dominated by the fetishistic faith in extracts and tinctures is now gradually freeing itself from the shackles of traditions and is rapidly becoming scientific.

Medical men are no longer afraid of anything mental, they no longer fear hypotheses and theories, the ferments and products of rationalizing scientific thought. They realize that hypotheses are not will-o'-the-wisps, but guiding stars; that theories are keys fashioned by the human mind to open the mysteries of nature; and that all science, in fact, is fashioned and moulded in the crucible of theoretical reflection. Phenomena must be rationally examined, experimented upon and scientific theories worked out, based on the broad foundation furnished by the acquisition of physical and biological sciences. In short, medical men have

come to realize the necessity of a rational scientific comprehension of the phenomena with which they deal. Psychology from hovering in the clouds of metaphysical reflection has descended into the laboratories and is now demonstrating its truths by means of instruments and experiments. The psychologist has donned the apron of the laborer and has turned his theories to practical account. Medical science has become more theoretical and psychology more practical. The chasm that separated the psychologist from the physician is bridged over by the medical study of nervous and mental diseases and by the scientific spirit that is now rapidly taking possession of the profession.

These, however, are not the only factors that have forced the medical profession into the arms of psychology; other factors have been at work and have perhaps been far more powerful, far more effective. The striking manifestations of subconscious life, the strange phenomena of hypnosis and the practical utility of psychopathic methods in the hands of the judicious practitioner were by the labors of such men as Braid, Liebault, Bernheim, Forel, Charcot, Janet and Sollier, forcibly brought before the attention of the medical profession.

The knowledge of subconscious phenomena is not new, in fact it dates far back into antiquity. The ancient civilized nations, the Chaldeans, the Babylonians, the Assyrians, the Persians, Egyptians, Hebrews, Greeks, were familiar with the upheaval of subconscious activity, they even knew of hypnosis and estimated, if not overestimated, its practical utility. The phenomena were, however, relegated by them to the province of the supernatural and to the present day the superstitious fear of subconscious activity and especially of hypnosis, still lingers among the vulgar.

In ancient times the knowledge of mental life and psychotherapeutic methods along with other germs of science were in the hands of the priests. There is in the British Museum a tablet, found at Thebes, that represents a priest hypnotizing a patient. The biblical story of the "brazen serpent," that cured those who gazed upon it, points in the same direction. Cures by hand-manipulations strikingly similar to the modern methods of hypnotism were performed in the temples of Isis, Osiris, and Serapis. In the Greek temples of Æsculapius diseases were cured by having the patient fall into deep sleep in the sleeping chamber near

the shrine of the God of medicine. Enormous sums of money were paid by the patients for such cures which were regarded as supernatural, mysterious, divine.

The apparently strange phenomena of subconscious life could not possibly, in the infancy of science, be investigated and analyzed into their constituent elements; they were therefore considered as supernatural or the manifestation of some God; they were connected with the mysteries of religion, and were essentially "faith cures," miracles.

This condition of things continued throughout the middle ages with the only difference that the phenomena, regarded in ancient times as work divine, were now ascribed to the agency of evil spirits or of the devil.

With the decay of blind religious faith and with the rise of the modern rationalistic spirit, miracles, faith cures with all the real phenomena that underlie them, valuable as they are in themselves, fell into disrepute. Medical men with their practical common sense tried their best to keep clear of faith and mysteries. In opposition to the claims of the priest-craft as to the possibility and actual occurrence of "miraculous divine healing," the medical profession rejected in a body all kinds of "faith cures" among which were phenomena of the most vital importance to medicine in general and to science in particular. The very existence of subconscious phenomena was emphatically denied as being but a fake of lying priests and delusion of vulgar superstition.

Meanwhile the rejected phenomena continued to manifest themselves; they did not disappear because of having been repudiated by the medical profession and exorcised by learned incantations or quasi-scientific formulæ. Time and again have these outlawed phenomena risen from their obscurity and have obtruded themselves on public notice, but only again and again to meet with the same fate of being thrust aside, neglected and persistently denounced as fakes and delusions. It is not so very long since a man of science in speaking of hypnotism gave utterance to the exclamation: "Even if these phenomena were true, they ought to be suppressed!" and this simply because they seemed to him to interfere with the symmetry of his scientific principles.

The scientific world of the 16th century ridiculed Copernicus'

"De Revolutionibus Orbis" and the learned men of orthodox science in conclave assembled solemnly declared: "Terram non esse centrum Mundi nec immobilem, sed moveri motu etiam diurno est item propositio absurda." New ideas will always meet with the opposition of the crowd, even if the crowd be scientific. When Pythagoras discovered his famous theorem of the right angle-triangle he offered a hecatomb, a sacrifice of one hundred oxen; since that time, when a new discovery is made, all the oxen tremble.

In spite of the bitter opposition, however, the facts could not be suppressed. Nature cannot be exiled, it streams through every pore of our being, and neglected in one shape appears transformed in another. The physician was just the one to stumble in his practice on these repudiated facts which puzzled him the more, the more medical book knowledge continued to denounce them. Medical men could not long be blinded by prejudices. Phenomena that could not possibly be overlooked even from a purely clinical standpoint forced themselves on their attention, I mean functional diseases in general and those known under the appellation of hysteria and functional psychosis or psychopathies in particular. In these diseases the physician is confronted by motor derangements, by sensory anomalies, and even trophic disturbances induced by no "organic" cause. They are frequently *induced psychically* and what is more, they are *psychically cured.* Hypnotic and allied psychic phenomena were rediscovered, brought out from their obscurity, were closely studied, rationally systematized on the basis of already accumulated scientific acquisitions, clearly and concisely demonstrated before the medical profession, and were finally acknowledged by the world of science.

From a psychological standpoint it is interesting to note how often a word, however unintelligible, fetches the fancy of the crowd, no matter whether that crowd be scientific or vulgar. As long as the phenomena of the subconscious order were not gathered within the fold, as long as they were running wild so to say, the facts were ignored and contemned, but no sooner did authorities recognize their existence by finding a label for them, than the sceptical disbelief and disdain changed to deep interest

and credulity. The label "suggestion" did yeoman service—it fetched the crowd and inspired the sceptics with faith.

No sooner were those "fake phenomena" recognized by science than they were found to be so common and so dangerous that many European countries had to enact special laws for their regulation. Thus the fact that serious physiological disturbances could be induced and cured *psychically* is now slowly, but surely bringing the best minds of the medical profession into close relations with the science of psychic life.

I must confess that in this respect the psychiatrist has gone far in advance of his step-brother, the neurologist. The psychiatrist is making himself thoroughly acquainted with the most fundamental principles of psychology and is not even afraid of pushing his investigations into the regions of philosophy and epistemology. This is certainly a good sign, for it is always useful for a true scientist who wants to expand the limits of his science to examine occasionally the very instrument by which science is fashioned. Such a procedure, in fact, is for the true scientist sometimes indispensable. It is the psychiatrist, such as is represented by Kraepelin and his school, who specially insists on the great value of the cultivation by the medical profession of psychology and its various branches for the better understanding of psychomotor life, both in health and disease. In this country and abroad the psychiatrist greets with delight all attempts to incorporate psychological investigation in psychiatric research work. It is enough for me to remind the members of this Association of a paper to this effect read before them by Dr. Eskridge last year. So earnestly does the psychiatrist realize the need of psychological knowledge that he finds it necessary even to instruct the attendant in the asylum in the rudiments of this science, a praiseworthy example of which is represented by the little psychological manual written for asylum attendants, by Dr. Burr, the Secretary of this Association. It is the psychiatrist who is making endeavors to raise the young science of psychopathology on the broad basis of psychology and biology; and it is once more the psychiatrist who in the person of Prof. Ziehen is not scared by the philosophical aspects with which the psychologist, and I say fortunately for him, must necessarily be acquainted. Prof. Ziehen has written his "Leitfaden," and has recently followed it up by an attempt of a more or less thorough

discussion in epistemology, or the science of Knowledge, in his pamphlet "Psychophysiologische Erkenntnisstheorie."

Meanwhile the neurologist in the insane pride of the all-importance of his research-work refuses to make himself acquainted with the broader and deeper aspects of psychology, and is on that account still clinging to the old long-abandoned psychological doctrine of independent metaphysical sensory entities, idols, images, apparitions, sensory doubles and ghosts of sensations imprisoned in separate cells, entombed in their respective graves or centers, in different regions and localities of the cerebral cemetery, and capable of miraculous resurrection. The chaotic associative dance of those images, sprites and hobgoblins, holding high carnival in revivalism, constitutes according to the neurologist the essence of mental activity. I always wondered as to the sources of the neurologist's psychology, none are ever mentioned unless it is a round game—one borrows from the other.

The neurologist ridicules the psychologist, the psychopathologist, the psychiatrist, as living on unsubstantial ethereal ambrosia, not suspecting that he himself is feeding on the crumbs from those very tables. How many of the neurologists who write essays and text-books on the different forms of aphasia, amnesia and other mental ailments ever heard of Hobbes, Locke, Berkeley, Hume, Reid, Cabanis, Hartley, Herbart, James Mill, J. St. Mill, Bain, Galton and others. Those who did hear of them simply disdain to glance into such philosophical, metaphysical "bosh," and much less to quote them as authorities. The result is that the neurologist but too often offers us, with a naïve but self-contented air, amusing psychological dogmas for which he has justly drawn upon himself the anger of Wundt who stigmatizes the neurologist's queer metaphysics of "aphasia psychology" as "revived phrenology." "The assumptions," says Wundt in his Outlines of Psychology, "that visual, tonal and verbal ideas are stored in special cortical cells, are not only the results of the grossest physiological misconceptions, but they are absolutely irreconcilable with psychological analysis of these functions. Psychologically regarded, these assumptions are nothing but modern revivals of that most unfortunate form of faculty psychology known as phrenology."

Fortunately representatives of the younger generation of neu-

rologists are freeing themselves from those deficiencies and are paying their tribute to psychology and especially to the newly-rising science, so much attacked by some neurological old fogies, I mean the science of psychopathology as represented by the French, German and English writers, such as Ribot, Janet, Binet, Fere, Sollier, Bernheim, Liebault, Dessoir, Meyers, Gurney, James and others, and in which our Pathological Institute had also the honor to participate.

This new spirit in the camp of the neurologist is voiced by Doctor Peterson, the President of the N. Y. Neurological Association in his inaugural address which one has to hail with enthusiasm, and from which I proceed to make the following quotations:

"We who are students of the phenomena presented by the normal and by the disordered nervous system, while we realize the enormous progress made in our province during the last twenty years, still feel that we stand but in the half-light of discovery, and that there extend far out before us innumerable pathways leading into unknown regions, wherein shines the dim and fitful light of new truths to be attained:" . . . .

"Yet, though some of these paths may not be open to us all, there is at least one of the roadways leading into the realms of the mind which any one of us may follow. It lies in the direction of the better clinical examination of our cases from the standpoint of psychology.

"The neurologist may garner a vast number of extremely valuable data by the application of some of the principles and apparatus of the new physiological and experimental psychology to the investigation of his cases of organic brain disease. These patients have rarely, if ever, been carefully studied in relation to their mental phenomena. We cannot yet tell what lacunæ may not be thereby discovered in the psychic unity of the affected individual. Our studies of aphasia have been remarkably deficient as regards their psychic side.

"In the investigation of the functional disorders of the brain, also, there are fine conquests to be made by means of recent psychological methods.

"While the neurologist has much to gain by following the psychological path in the study of neurological cases, far more

vast is the expanse that opens out to physicians in reformatories, prisons, institutions for idiots and asylums for the insane, if they will travel the new road, under the new guidance, in the dawn of the new day.

"When I look back upon three years spent in asylum work without light or guide, it seems to me that, aside from some practical gain in methods of management of patients and a certain familiarity with types of insanity acquired, I traversed a somewhat barren waste. It would be an inestimable privilege to live again through such opportunities, to be awake and not asleep, no longer benumbed by the slumbrous psychiatric dissertations of that day." . . . . . .

"Ever since I observed the splendid facilities for study in some of the foreign psychiatric clinics, it has seemed to me a misfortune that not one of our large cities on this side of the water is provided with such a center for psychological investigation. The psychological laboratories attached to some of our universities, dealing, as they do, with the normal mind, can never hope to accomplish as much in the way of new discoveries as similar foundations associated with clinics for nervous diseases or asylums for the insane, where is gathered together an abundant morbid matter upon which to draw for the solution of many a psychic riddle. For it is true that most of our knowledge of normal functions of the human body, physiological or psychological, has been gained through investigations conducted when these functions were perverted or destroyed by disease."

Dr. Peterson might have also added that "psychological and neurological research would prove itself specially fruitful along the lines of the subconscious and functional psychopathies."

Not afraid of being called an enthusiast, Dr. Peterson with the true courage of a pioneer calls the attention of the medical profession to the rich region lying open with limitless horizon before every physician who has to do with morbid minds, with abnormal mental life in his private practice, or in special institutions, if he but follow the new paths.

Such is Dr. Peterson's earnest plea for the study of the psychological sciences by the medical profession in general and by psychiatrists and neurologists in particular, and we sincerely hope that the best medical men are in full accord and sympathy with Dr. Peterson's ideas.

It is true that some physicians with a limited stock of intelligence, a species from which no profession is free, sneer at all psychological research work and parrot-like repeat the word "imagination" as an explanation for phenomena that lie beyond the ken of their comprehension, and outside the province of their text-books. By the term "imagination" they seem to indicate a *something* which is essentially delusive in its character, a mere *nothing*, and with the dignity of people proud of their "doctor's" degree they can afford to look down on the poor creatures who busy themselves with such foolish "imaginary" things, with mere "nothing." It is interesting to observe that the consideration of how "nothing" can possibly produce any effects at all never occurs to their minds, but then mind itself is for them "imagination," mere "nothing." A "nothing" that alleviates suffering, that annuls pain like an anæsthetic, a "nothing" that may bring in its wake, or have as its concomitant serious disturbances, grave diseases, is certainly a wonderful species of nothing. Fortunately this type of men forms but a very small minority of the medical profession, it is a type that is now rapidly dying out, and will soon become a historical curiosity. Now it is certainly plain to the medical man, who has a good scientific training, and happily the majority of them do have one, as the profession now imperatively requires it, that the word "imagination" used as an explanation of the whole field of functional psychosis, the phenomena of hypnosis, the manifestations of the subconscious and also the methods of psychotherapeutics based on these phenomena[1] is simply a term that indicates an abyss of ignorance. The psychophysiological processes that underlie functional diseases must be carefully studied, faithfully investigated before an explanation can be given of their nature. To be satisfied with a word is certainly not a sign of scientific intelligence. Where thoughts fail da stellt sich zu rechter Zeit ein Wort hinein.

How often men stultify themselves with phrases, void of all

[1] I take here the opportunity to point out the fact that neither is hypnosis the whole of psychopathology nor is therapeutic hypnotization the whole of psychotherapeutics. Psychopathology covers the whole domain of abnormal mental life and hypnotization is but one of its many methods of study and treatment.

sense, we can see from the following account of functional neuroses taken from a German authority whose work is a standard text-book in the medical colleges of this country and abroad.

"If the normal exertion and inhibition of the will-power be broken down, so that *unreasonable* will-stimuli are created and reach the muscles we have hysterical convulsions, contractures, or cramps. If there are present in the consciousness images of awaited or feared objects, and if these images be intensified by the conditions of the disease into *true subjective irritations* of consciousness, we shall have hysterical pains and neuralgias." This piece of scientific speculation, as to its lucidity reminds one of the definition of love given by a Platonist: "Love is the ideality of reality of a part of the totality of the Infinite Being."

In spite, however, of all this confusion in the camp of the neurologists one thing remains true, and that is, that the majority of the medical profession which consists of men possessed of an inquisitive and scientific turn of mind is, through means of functional psychoneurosis, brought to the portals of the temple of psychology. Especially is this the case with the specialist in mental diseases. Daily is he confronted by phenomena, the source and mechanism of which can only be understood in the light of psychological analysis.

It is to be hoped that the time is not far off when every medical college of high standing will institute courses in psychology and psychopathology.

A few words must be said here of those medical men, who are still suffering from phrenophobia, who are afraid of "thought." Psychology takes one into deep waters, psychology is philosophy they say, and advise their friends to keep at a distance from psychological knowledge. Thus a well-known neurologist in an address before a medical association warned the profession against the dangers of psychology, and another neurologist advised in good faith the director of a well-known scientific institution to steer clear of all psychology, as it is pernicious to all solid work, it neither spins nor weaves, it is mere moonshine, dealing in flimsy material such as our dreams are made of, it is nothing but "mere thought." A psychic fact is something that cannot be put in any hardening fluid, nor cut into slices, nor put on slides, nor

stained, nor put under the microscope and then represented in so many figures and pictures. In short, it is mere thought. And what is thought? Metaphysics! Cells and stains, that is real science!

Now psychology is by no means the same as philosophy, still the field of psychology is wide, and while on the one hand it extends far into the domains of physiology and pathology, it at the same time closely borders on philosophy, and the psychologist must also be somewhat of a philosopher, in order to comprehend clearly the phenomena he deals with, and do good, efficient work. But even if psychology had much to do with philosophy, there is no reason why medical men should be afraid of it. Psychology, and especially that part of it that deals with abnormal mental life, has proved to be practically useful, and philosophy is certainly not dangerous. Philosophy is after all only clear thinking, and is there any special reason why medical men should not be clear thinkers? Surely, thought is an ally, not a foe. Medical men ought to remember the golden saying of Hippocrates, the father of medicine:

ἰατρὸς γὰρ φιλόσοφος ἰσόθεος.

"Godlike is the physician who is also a philosopher."

OUR WORK AND ITS LIMITATIONS.

By EDWARD C. RUNGE, M. D.,
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At the outset let me state that I lay no claim to represent a class or to speak for a class. By "our work" I mean my reflections upon the work of those engaged in the actual care and treatment of the insane—reflections that are not the offspring of an idle fancy, but the result of hours replete with anxious doubts and heart-burnings. When I first faced the large, compact mass of living material so temptingly spread before the eager eye, I, like many others, resolved upon a course that promised to lead to the achievement of something telling, something lasting. Since then I have undergone a clarifying process which has resulted in my resigning myself to our limitations; I have learned what I could and could not do, thus finding the guiding star to what I should and should not do. It does not require a very extensive training in the exact methods pursued in experimental laboratory work of to-day, to recognize the fact that psychiatry as at present constituted, falls far below the standard of an exact science. Psychiatry is still an art and not a science. Truth is a hard task-mistress, and to her mandates we yield, cheerfully if we can, unwillingly if we must. Many a year of careful research-work in different fundamental branches of science, will have to pass before psychiatry may be able to don the truly scientific garb; then, and not until then, shall we recognize the true nature of psychic disease and its causes, which would pave the way to rational therapeusis. There is no valid reason why we should shrink in shame from such a confession, considering that exact methods in the investigation of disease, are products of our own era, following closely in the wake of the late evolution of those branches of science without which, scientific medicine would have remained unborn. Except for a few isolated flashes illuminating here and there the utter darkness of past ages, we must look to

our own, the nineteenth century, as the soil on which the entire structure of modern science has grown. With Lavoisier's chemical balance, and Berzelius' discovery made in 1811, that the composition of organic substance is based on the same infallible laws as that of inorganic matter, chemistry received the impetus to its wonderful development. Physiology and physiologic physics could not possibly have grown without the great number of instruments of precision, which the mechanical genius of our time has evolved. Galvani and Volta made their discoveries in and about the year 1800; without these, nerve and muscle physiology would not have attained its present respectable size. It was by Professor Schleiden, in a memoir published as late as 1837, that the existence of the vegetable cell was established. About the same time, Schwann showed the analogy between the vegetable and the animal cell. The microscope, after its achromatic correction at the commencement of the second quarter of the present century, had ceased to be a pretty toy in the hands of the curious scientist. The entire microcosmus of cell-existence, cell-life and activity, was doomed to remain *terra incognita* until the miscroscope disclosed new avenues of research. Without the long chain of microbic discoveries, Behring's antitoxin would never have seen the light of day. The late development of medicine as a science, was necessarily shared by psychiatry: it can be readily understood why the latter could make but slight headway, considering that it deals with the structurally and functionally most complex organ, the brain. The advances made in recent years, which have led to unraveling the intricate mesh-work of brain structure, have not resulted in positive knowledge about the true relation between cerebral structure and cerebral function. Who would have the hardihood to contend to-day, that the enthusiastically received "neuron theory," has definitely settled that all-important question? What is true of psychiatry, is to a great extent true of neurology. The peripheral nervous system, the spinal cord and even the apsychic portions of the encephalon, are so much simpler in function and so much more accessible to the comparative physiologic experimentation than the psychic centers, that it would have been surprising if neurology had not succeeded in outleaping psychiatry, and in establishing the interrelation between disturbed function

and any particular lesion. But whenever the inquiry is pointed in the direction of the nature of the pathologic process and etiologic factors, the neurologist of these latter days is obliged to profess utter ignorance as much and as often as the psychiatrist. The almost entire absence of positive knowledge in the direction indicated, accounts for the fact that apparently rock-ribbed, pathologic entities of to-day, are to-morrow merged into clinical types of the same disease. Let me but point to progressive bulbar paralysis, progressive muscular atrophy of the Aran-Duchenne type, and myoatrophic lateral sclerosis. Not so very long ago, these were treated as wholly dissimilar, morbid conditions, while to-day everything points to their being different phases of the same disease. I am expecting that this tendency to amalgamation will, in the near future, link together two diseases that are thus far considered as utterly dissimilar—I mean tabes dorsalis and dementia paralytica. Their apparent relation to the luetic subsoil, the usual limitation of the morbid process to certain portions of the cord and brain, the striking similarity of some symptoms, as optic atrophy and iridoplegia, the gray degeneration of the columns of Goll encountered in the so-called dementia paralytica ascendens—all these seem to indicate the identity of the pathologic process; the differences may be accounted for by local conditions prevailing in the cord and the brain.

Dr. Edward D. Fisher closed the discussion on the subject of myoatrophic lateral sclerosis at last year's meeting of the American Neurological Association, with the expression of hope that eventually the influence of the past would be shaken off, and a new and more correct classification of these (the above-quoted) diseases would result. This has an undoubted bearing upon psychiatry—old ways and methods of getting at the truth, will have to be revolutionized before psychiatry can be said to have safely started on the road of truly scientific research. Two questions have been foremost in my mind: first, are we moving toward the advancement of scientific psychiatry in the work done at our hospitals? Second, should we be expected to engage extensively in original research-work? My answer to both these questions is an emphatic "No."

At a glance over the reports emanating from the hospitals for

the insane, we find that the annual grist-mill grinds out with painful regularity, a bewildering mass of statistic tables, the persistent appearance of which can only be interpreted as an attempt to add to the advancement of the world's knowledge in matters psychiatric. These tables have been actually referred to as "scientific" tables. Here we have the nativity, civil condition, religion and occupation of our patients faithfully recorded and officially tabulated. The constancy with which these data are incorporated in the hospital reports, can be explained only by a desire to show some causative relation borne by the former to insanity. The fact that false deductions are frequently made from such statistical material cannot be gainsaid. In illustration I shall quote from my last, as yet unpublished annual report: "A gentleman endowed with superior intelligence, addressed a card to one of our local newspapers after having carefully perused my annual report for the year 1896-97. From it he had learned that of 158 women admitted during the year, 104 were classified as domestics. These figures suggested to him the propriety of sounding a note of warning to our housewives whose treatment of their servants seemed responsible for such an alarming preponderance of insanity among the latter. Table No. 9 of the present report shows that of the total of 200 insane women admitted, 108 appear as having done housework, and 26 were domestics; of the 184 men admitted, 33 were common laborers. We should not be unmindful of the fact that a charity institution located in the heart of a large municipality, draws chiefly upon the more lowly strata of society. For the same cogent reason do we meet in the State hospitals of farming States, a large number of farmers' wives, while in the State of New York, for instance, out of a total of 20,994 women admitted between October 1, 1888, and September 30, 1897, only seven appear as having followed agricultural and pastoral pursuits. Local conditions determine the character of the population in public insane hospitals, and I am of the opinion that the occupation of the individual patient has in reality little or no connection with his or her psychic malady. When a house-painter becomes insane, the cause is not to be sought in the mere performance of his daily labor but in the poisonous effect produced by the lead-laden paints which he handles; in short, we face here a case of drug-

poisoning differing in its manifestations, but analogous in nature to poisonings by alcohol or morphine. European statistics point to the existence of insanity to an alarming degree among the soldiery, particularly the commissioned officers. No one should be misled into the belief that military life as such has much to do with this fact: excesses of all sorts, with their natural allies in the shape of sexual disease incident to military life, are the real determining factors in this instance. . . . It is my firm belief that the civil condition plays but an unimportant rôle in even remotely causing insanity. The incidents and accidents in any individual's married or single life, are so varied that no deductions can be made from such vague statistical material. An examination of Table No. 13 and the corresponding tables in former reports, may possibly tempt some to jump at the conclusion that native Americans are more frequently sufferers than the foreign-born citizens, as the former by far outnumber the latter. A simple, arithmetical calculation establishing the proportion between the native and foreign population of this city and the numbers of insane belonging respectively to one or the other class, will easily prove the utter fallacy of such a contention. If it has been found that the idle lazzaroni of Naples furnish smaller quota to the sum total of the world's insane than the Irish peasantry, it is because the picturesque Italian of that type is able under the blue skies of sunny Italy to eke out a half-way comfortable existence on next to nothing, while the Irish peasant must often face absolute starvation and innumerable hardships—in short, nativity bears no relation whatever to insanity. Regarding religious creeds, I have stated in a previous report that the fact of our having such a large number of Catholics among our patients, is readily explained when we consider that St. Louis counts as its citizens, a great many members of this particular denomination. A healthy religious trend, without a taint of morbid emotionalism, certainly does not lead to the development of psychic disease. The so-called 'religious' mania afflicts more often persons who have led lives devoid of all religious scruples, as confirmed drunkards, rakes and prostitutes."

Thus far my quotation. No possible objection can be raised against continuing the practice of glutting the world's literature with those statistic tables, but it should be made clear that they

throw about as much light upon the scientific problems of psychiatry as the table showing the annual yield of our farm and garden. Now I come to speak of the table showing the alleged or probable causes of insanity, which has always been my particular *bête noire*. Here no attempt is made to separate the wheat from the chaff, the probable from the improbable. Domestic infelicity, financial reverses, worry, ill-health, disappointment in love—that "broken heart" of the poet—and other incidents of human life, represent worthily the beautiful hodgepodge of lay-notions. The very nature of this statistic material and the manner of its tabulation, point unmistakably to bold guesses by the sufferers' kindred, which are elicited in the anamnesis and preserved in their thin pseudo-scientific garb to wondering posterity. I have been astounded to find insane heredity placed on an equal footing with the above-quoted galaxy of highly problematic causes as if the hereditary predisposition were not in most cases the determining factor in creating the essential subsoil in which the pathologic process most readily roots and grows. Even though there is cumulative evidence that some sort of causative relation exists between psychic disease and such agencies as puerperium, trauma capitis, insolation, infectious diseases, particularly lues, alcoholism and other drug-poisonings, we are still in utter darkness about the real *processus* and *causa morbi*. This deplorable inability of fathoming the true nature of psychic disease, makes itself keenly felt in our classifications of insanity. The grouping of insanities, as psychoneuroses, psychic degenerations, organic psychoses and developmental psychoasthenias—is of undoubted practical significance, especially as their proper and timely recognition has great weight in the prognosis of each individual case. But the absence of all exact interpretation of the pathologic process renders the scientific value of such a classification highly questionable, to say the least. Take, as an illustration, a genuine functional psychosis and one that so often appears in the course of dementia paralytica: clinically the differential points are readily enough established, but can this be said of the morbid process which engenders these clinical manifestations? The earlier we recognize the fact that clinical methods of investigation will never lead to the solution of the essential nature of psychic disease, the sooner will psychiatry reach the

dignity of a true science. I profess that I have no reverence for the old simply because it is old and hoary, for the traditional because it has thus far been accepted as the alpha and omega of our knowledge. Why should we shrink from the destruction of time-honored scientific idols when it will be followed by the erection of a structure grounded solidly on exact methods of modern science?

After admitting humbly the utter inadequacy of our present mode of procedure, we must ask ourselves the question how we, whose life-work lies among the insane, are to proceed to add even a single jot to the future science of psychiatry? We could do more than that, if we were given the proper facilities with all that these imply. We should be able to satisfy the most exacting demands for original research-work by the establishment at each hospital, of fully-equipped laboratories, by the employment of the best skill in the different branches of scientific research, and by the transformation of our asylums and hospitals into sanitaria which would attract all incipient neuropathic and psychopathic patients. Is this feasible? Will such favorable conditions ever prevail except within the confines of visionary dream-life? There is no reason why we should give ourselves up to idle speculation when the way out of the difficulty has been clearly shown to us by the State of New York in the creation of its Pathological Institute where, if untrammeled by traditional views, if fostered by a true scientific spirit, psychiatric science would promise to grow to what it should be. The immense scope of the work at such an institute is best shown by naming the different branches of science that enter into the sphere of its activity; here we find: psychology, psychopathology, experimental physiology and pathology, cellular biology, pathological anatomy, comparative neurology, physiological chemistry, anthropology and bacteriology. The work in some of these branches must necessarily be done at the hospitals; but even there, to be of value, it must be performed, under the direction of a specialist, by trained assistants whose methods should be faultless and beyond reproach. No valid objection could possibly be raised to the pursuit of such work by our assistants and ourselves even under conditions prevailing at present, but we should certainly not attach to our labors the intrinsic value possessed by the work of thoroughly trained

specialists. In this connection I may quote the following passage from the report of one of the hospitals, received some time ago: "The scientific work in the medical department is kept well abreast with the advance of the day. . . . The pathological laboratory serves a most excellent purpose; it is of great value not only in the matter of diagnosis but in the accumulation of most interesting material." And these words emanating from an institution that, to my knowledge, has never startled us by particularly progressive work. I firmly believe that such words embodied as they are in a report to superior officers, *i. e.*, boards and legislatures, are bound to create the impression that the work done at that particular hospital promises to advance greatly psychiatric science. As long as we hide under the cloak of self-satisfaction, relief will never come to us. Bold, oft-repeated confession of total absence of opportunities for research-work would eventually arouse popular opinion to a sense of realization of our real needs, and with the growing popular opinion as a *vis a tergo*, the law-making bodies of every commonwealth would rise to the occasion by following the brilliant example set by the State of New York. The demands made on the hospitals for the insane for startling, epoch-making discoveries are manifestly absurd under present conditions. It is but too frequently forgotten that the man at the helm of a hospital for the insane, is, first of all, a practicing physician. The fact that the peculiar nature of his patients necessitates their aggregation in large numbers under one roof does not affect the truth of the above proposition in the least. He should be a scientific physician, and by this is meant one who will absorb and digest all intellectual pabulum offered by his science, who will ever keep abreast of the times and who understands how to apply the thus accumulated knowledge for the benefit of his patient. The scientist, on the other hand, is the man who evolves scientific facts and truths, and to him we must look for advanced knowledge and new methods. No river can ever rise above its source.

In the foregoing I have attempted to point out our limitations which are not rarely commented upon by self-constituted critics, who, as a rule, are completely ignorant of the work accomplished in the hospitals for the insane. I shall ever remember the following exclamation of one of these critics, made at the meeting of a

neurological association: "What have these hospitals ever given us? Not even a book has come to us from them." He did not realize that the latter circumstance was certainly a cause for genuine congratulation, for a new book on psychiatry does not mean simply an addition to medical literature but it also means, *horribile dictu*, a new classification. In my opinion, the best works on psychiatry as an art have been written, while such on psychiatry as a science must remain products of the future. I never could see why so much veneration should be bestowed on the man "who wrote a book," for a really good book is at all times and in all lines a *rara avis*, while the writing of a mediocre one presupposes nothing else than the possession of some knowledge, a facile pen, and a great deal of dogmatism.

Many of us at some period of our lives may have stood at the parting of the ways, one leading to the career of the scientist, the other to that of the physician in active practice. After having chosen the latter, have we any valid reason for regret, or for feeling humiliated over the narrow scope of the field of our labor? I, for one, firmly believe that we may calmly resign ourselves to our limitations, and still have great opportunities for work that will tell in more than one direction. First of all, the insane as a class must look to us to bridge over the chasm yawning between them and their fellow men. Who would deny that the difficulties encountered in finding support for improvements essential to the treatment and comfort of the insane, arise chiefly from the utter ignorance on the part of the people at large regarding the nature of insanity and the insane. Superstitious notions, handed down from generation to generation through centuries of almost complete intellectual stagnation, die hard; the death-blow must be struck by us whose special training and knowledge command respect in our respective communities. Outside of the deeply-rooted misconceptions of everything pertaining to the insane, there are some plain surface indications pointing to the great need for an unremitting propaganda of modern views. Within the borders of a commonwealth which has ever borne the emblem of intellectual progress—in Massachusetts—we find a monument erected to the memory of antediluvian psychopathology in the abominable name "Lunatic Asylum." What dangers even to our present achievements, threaten from men who are apt to

mold public opinion, was clearly shown when, only a few years ago, the governor of the State of New York branded the insane in the public hospitals with the appellation "paupers," strongly advocating in his message, considerable retrenchment in expenditures for their support. The gist of his remarks was that these paupers were treated entirely too well; a sentiment calling for most forcible condemnation. A fruitful object for thorough missionary work is the field of politics, which in many States still embraces our public institutions. The Jacksonian motto, "the spoils belong to the victors," has there full sway; actual merit, scientific fitness and ability are cast ruthlessly to the winds, yielding the palm of supremacy to political preferment. At some hospitals this diabolical influence makes itself felt down to the very lowliest dish-washer. It was the cause of profound distress to me when I learned that there was at least one medical man in charge of a hospital, who, by his own acts, fostered this spirit of political qualification. An ex-attendant applied to me for employment, presenting a letter of recommendation worded by the said superintendent in language so highly eulogistic, that he would have passed anywhere for the *beau ideal* of an attendant had he possessed only one-half of the attainments ascribed to him. I brought out through some questioning that the superintendent had expressed his regrets when calling for the attendant's resignation, saying that he needed the place for a friend of his. Such a man is utterly unworthy of the high trust bestowed upon him, and should be loathed by all good men. If occurrences of such a nature are possible in a hospital presided over by a "Medicinæ Doctor," what is to be expected of institutions that are euphemistically styled county asylums while they really are almshouses for the insane? In a solid phalanx, with written words and words of mouth, we must stem the tide of retrogression, which has shown a dangerous tendency to engulf some of the best intellects within the precincts of several commonwealths. If all counties were possessed of a high degree of enlightenment and of financial prosperity, they might safely be allowed to solve the problem of the care of their insane. But could this be done with any degree of safety in counties whose poor-farms to-day are veritable breeding places of vice, presenting in every detail the picture of utter neglect? We should not rest until the talk of

introducing the county asylum system is silenced beyond hope of revival. Let State-care be our goal, and by that I mean the real, unvarnished article, not the one that passes for the former but in truth represents congregated county-care, each individual county being interested exclusively in its own insane. The process of public education should lead to the establishment of homes and schools for imbecile children, of colonies for epileptics, and possibly, of colonies for the chronic insane.

In the foregoing I have attempted to call attention to some vital points that could profitably form the subject of persistent agitation. How are we to proceed to make this agitation as far-reaching as possible? It is certainly not sufficient to discuss these matters at meetings or among our intimates—in such a manner we shall never succeed in reaching the large mass of people whom we must win over to our way of thinking before results may be hoped for. I repeat again that this broad, educational work can best be performed by means of the reports emanating from our hospitals for the insane. "In order to do this successfully the nature of these reports, in most instances, must undergo a radical change. Simple statements of facts and figures regarding operations, administrative improvements, and defects, make dry and unprofitable reading, and promise no educational results. We must infuse ideas into our reports—ideas dealing with the vital problems of insanity and the insane generally; we should not hesitate to dip into the individual lives of our patients, and relate incidents that may bring the sufferers into closer communion with the reader; in short, let us write our reports so that they will be readable, and read by intelligent members of our respective communities, who are not engaged in institutional work, and who are not statisticians. An aggressive, unceasing agitation conducted systematically, year in and year out, through the territory tributary to every hospital for the insane, must eventually bear fruit in disseminating true knowledge of the insane and their needs. With such knowledge will come a broadening of sympathies, which will go far toward helping us in our single-handed struggle for the most advanced methods of their treatment."

Wherever our hospitals are located within the reach of a center of medical education, we should invite the clinical instruction of

the medical student in matters psychiatric. During the last four years, I have had the pleasure of conducting a double course of clinical demonstrations for students, and another for a limited number of young practitioners, and I am certain that I have succeeded in impressing their minds with the importance of comprehending some phases of our work. We should not be unmindful of the fact that the student of to-day will be the physician of to-morrow, and that the importance of the sympathetic support of the medical profession should not be underrated. I should be glad to see our hospitality extended to the student of law, for the legal profession presents a great field for dissemination of modern conceptions of insanity. Reform in legal proceedings against the insane, in which the latter are treated as criminals guilty of the heinous crime of "mental unsoundness," can only be instituted with the help of the legal profession. No one, unless possessed of a mind steeped in prejudice, will deny that the present *de lunatico inquirendo* procedure is utterly out of date; and there are other instances pointing clearly to the great need for reform. I cannot close this chapter more fittingly than with an appeal to the members of this association to join hands in the battle against superstition and prejudice. The insane rightly look to us for protection and for advancement of their interests.

Thus far I have tried to outline our work *extra muros*, which, perhaps, is slow to show results, but perseverance and tenacity of purpose have won victories before. *Intra muros* lies the arena of our real labors, the fruits of which are immediate. We need not await startling discoveries from scientific laboratories and institutes, to proceed with improvements demanded peremptorily by the present state of our knowledge. Most of us have no training schools for nurses, which are so essential a factor in the proper care of the insane. No effort should be spared to establish such schools at every one of our hospitals, and once established their graduates should receive higher compensation for their services than the one in vogue to-day. With the improvement in quality should come an increase in numbers. The more good attendants we employ, the more closely we are able to adhere to the principle of individualization which is the *conditio sine qua non* of successful treatment of many of our patients. Individualization cannot possibly be carried too far in dealing

with the insane. In connection with this, I desire to condemn most forcibly the so-called congregate dining-room plan, which has found quite a number of advocates chiefly on account of its labor-saving features. There may not be any valid objection raised to the herding together of terminal dements and idiots in common dining-rooms, but convalescents as well as chronic insane with only slightly impaired intellectual power, could hardly be expected to derive much comfort from those large feeding-places. Even the addition of orchestral music during the meals as suggested by the late Dr. Rohé, would certainly not outbalance the distasteful features accompanying such indiscriminate mingling of different classes of insane. In order to test the soundness of my conception I submitted the question to a vote by my patients, and they unanimously decided in favor of their present separate dining-rooms furnished with small tables seating four congenial companions—music or no music. The solution of such problems can safely be entrusted to those directly concerned. Speaking of dining-rooms, I will allude to one feature which I was made acquainted with, in at least one hospital. There I found the patients' tables adorned with beautiful linen which made me positively envious until I learned that this linen was removed before each meal; in other words it was part of a general display for the benefit of the admiring visitor. This is not only a piece of the most reprehensible deception practiced on the unsuspecting visitor, but it must affect injuriously the self-respecting patient who sees himself considered unworthy of eating at a table so temptingly adorned between meals. What does not directly or indirectly bear some relation to the welfare or well-being of our patients, should remain undone; not an inch should be yielded to idle display for the benefit of visiting boards and other visitors. In devising any improvements not a thought should be given, not a concession made to the possible effect they may have on any one except our patients. The spick and span order encountered in the visiting wards of some hospitals, with the attendants silently reposing in easy chairs—and with the whole picture held down to a tone of appalling listlessness, is surely not to be commended for imitation. To change the mere shell of a house into a home, it must bear unmistakable signs of human habitation and human presence. My heart goes out to a ward with

papers and books strewn around, with chairs scattered here and there, instead of being strung out in truly martial style—in short, to a ward breathing active, vigorous life!

In expressing, in the beginning of my paper, the hope that rational therapeusis would soon supplant our present empirical methods, I did not intend to convey the idea that we stand utterly helpless to-day in dealing with psychic disease. That all somatic disturbances carefully elicited by means of approved clinical methods are to be dealt with in the insane as in the sane needs no further expostulation. All our efforts must necessarily and chiefly be directed toward correction of functional disturbances of the vegetative organs and the improvement of the general nutrition with the hope of impressing favorably the general nervous system. I have heard as one argument, set forth against the consideration of insanity as a symptom of actual brain-disease, that in some cases the general nutrition had reached a high degree of perfection while the manifestations of the psychic disease still persisted. What do we know as yet of the chemism of the highly specialized brain-cell? May we not justly assume that there are special nutritive conditions essential to the structural completeness and functional well-being of this cell—conditions which cannot be recognized by the increase of avoir-du-pois, nor by the use of the hæmatinometer, or hæmoglobinometer? Unfortunately, popular belief in the existence of specifics for the restoration of disturbed psychic function, is not founded upon actuality—all we can do is to affect favorably psychic function with psychic agencies. Here we imitate as closely as possible nature's course when she stimulates the growth of the infant's brain by means of peripheral impressions. Cheerful surroundings, useful employment, entertainments and other agencies of similar nature, have for their ultimate aim the production of healthy cerebration. But among psychotherapeutic agents, one is of special importance, and that is our own psychic self freely and generously offered to our patients. Our own personality must wholly enter into their existence; from us they must sap invigorating strength and vitality. In the direct communion of our minds and our souls with theirs lies the chief secret of success in psychotherapeusis. The task may prove at times wearying, but, to do our work conscientiously, we cannot shrink from it unless from healers of human

kind we are willing to sink to the level of mere custodians of so much human flesh.

In thus cursorily reviewing the work before us, we may well ask ourselves: Must we fear our traducers' bolts? When hundreds of our patients—who in the course of years, are reclaimed to their homes and to spheres of usefulness—part from us with grateful hand and heart, have our lives been truly lived in vain? If our work is done not with the lukewarm love of the bread-winner but with the love of the enthusiast, we may calmly turn our glance at duty well performed—at our mission worthily fulfilled.

THE PUERPERAL INSANITIES.

By H. A. TOMLINSON, M. D.,
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The time has come to recognize, in the study of insanity, what is gradually coming to be appreciated in general medicine—that is, the third element in the equation. Beside the disturbance or aberration of cerebral functioning and the different factors which stand in apparent causal relation to the manifestations which result, there is another element the importance of which is not commonly understood and its necessity to the completion of the equation not fully appreciated—I mean the cerebral potentiality of the individual. Further, the form in which the insanity may be manifested is not the product of any specific cause, resulting in the development of a definite symptom group; but on the contrary a process, varying within wide limits as to intensity and form; dependent upon the degree of defect in the individual for its extent and upon his environment for the nature of its manifestations. It is true that mental aberration is frequently associated with the different developmental epochs in the life of the individual, and in women especially with puberty and maternity. But to say that puberty, the period of adolescence, or maternity, stands in causal relation to any particular form of insanity seems to me to be an unwarranted assumption, when we take into consideration the fact that all women pass through the epoch of puberty and period of adolescence and most women bear children, but only a comparatively small number ever become mentally disturbed as a result. Besides when mental disturbance does occur it is most frequent among primiparæ, and bears no direct relation to the condition of the mother during the period of gestation, the severity of the labor, the presence of disease during the puerperium or the exigencies of the period of lactation. However, mental alienation occurring during any one of these periods does bear a constant relation to the degree of defect in the nervous

organization of the woman and the amount of this defect will determine the extent of the insanity, the point in the cycle of maternity at which it will be manifested, its form, nature, and termination.

In this end of the century, when women are warring against their natural position in relation to the reproduction of the species; while the competition of social and industrial life and the growing desire to avoid any responsibility which interferes with material advancement or social opportunity is so strong, it is not surprising that we should find so many disturbances of the nervous system associated with the bearing of children; or that this originally physiological function and process should be credited with the untoward results which so often accompany and follow it. The man in the general practice of medicine, whose experience has brought him much in contact with the pregnant woman, who afterward has watched the process of parturition, the events of the puerperium, and become familiar with the disturbances of the period of lactation, comes to be largely influenced, in his estimate of the future of the mother and child, by what he knows of the mental make-up of the mother and how she responds to the conditions in her environment resulting from the stress of domestic and social experience.

There are probably very few women who enter upon the period of gestation without some misgivings and more or less resentment because of the physical discomfort connected with their condition, as well as the annoyance resulting from interference with their pleasures and social opportunities. It is certain also, if she has borne children before, that the mental attitude of the woman toward her condition will be largely influenced by personal experience of the discomforts, annoyances and dangers of maternity. Aside from the occasional woman in whom the function of child-bearing continues to be a physiological process, there is practically always more or less disturbance of health during pregnancy, either mental or physical, and when we remember the intimate association of the nervous system with the functional activity of the reproductive organs in women and how quickly disturbance in one is responded to by disturbance in the other, we ought to expect that there would be a more or less intimate association of mental disturbances with child-bearing.

Again, on the physical side, we have to consider the effect of accident and disease during the period of gestation, complications of the act of parturition or its excessive prolongation, on account of disease in the mother, deformity or malposition of the child—and so often in this country to disproportion between the child's head and the pelvis of the mother, on account of racial admixture. Following labor are the risks from post-partum hemorrhage, septic infection and the ill effects of subinvolution; while during the period of lactation her inability to nourish both the child and herself, or the strain of its care in addition to other duties, may seriously affect the health of the mother and, therefore, the welfare of the nervous system.

The effect of pregnancy upon the nervous system of the mother and the peculiar susceptibility of women to causes of mental disturbance during the puerperium are so well known, even among the laity, as to have resulted in a definite tradition, with certain conventional rules for the conduct of the pregnant woman and her environment during the puerperium. These ill effects seem too to increase with civilization and its requirements. In other words, along with the increased capacity to enjoy, there goes a proportionate tendency to suffer; so that while frequent child-bearing, over-crowding and bad surroundings in the tenement districts of the city, and exposure and over-work in the country among the poor, bring a train of physical ills to complicate maternity; high pressure, intellectual life and social competition have an equally disastrous effect upon the well-to-do. So that whatever weakness or defect may exist in the mother is exaggerated by her condition, and what was originally a physiological process becomes a pathological one; out of which develops a host of conditions, most of which are temporary, but often they destroy the physical or mental health of the woman. In my own experience, however, the two seldom exist together; nor do they, by themselves, merge into each other. It is true that the pregnant or parturient woman is frequently hysterical or neurasthenic, because of the nervous instability brought about by untoward conditions in her environment, operating during the cycle of maternity; and there may and do develop marked changes in her character and disposition; but these disturbances disappear after the birth of the child. Some women, on the contrary, are strong and healthy

only while pregnant. To my mind the various disturbances associated with maternity simply prove what we know as a physiological fact; that is, the intimate association between the function of reproduction and the activities of the rest of the organism, while the greater instability of the nervous system in women renders conspicuous and prominent those changes which the concentration of her vital forces in the process of reproduction makes possible and renders apparent; because under modern social conditions, the nervous system is not equal to the task of controlling its own manifestations and meeting the extra demands upon it. But when we come to consider insanity in relation with maternity, the laws which govern the association of other disease conditions with pregnancy and the puerperium apparently do not apply. In the first place insanity occurs most frequently among primiparæ; it most often complicates an otherwise normal gestation, or follows a natural labor. Indeed in my own experience insane pregnant women have been singularly free from physical disease and almost invariably have normal labors, free from complication of any kind.

I have selected from the records of this hospital sixty cases illustrating the different forms of mental disturbance associated with the different periods in the cycle of maternity. Of the cases included in this report I have been enabled to get a detailed history of the individual in about half of the number, and in all of these cases there has been more or less definite evidence of mental disturbance at the period of puberty and during adolescence. The manifestations varied from wilful assertiveness and its converse seclusiveness, to marked aberration, mental reduction and suicidal impulse.

Case Number.	Degree of defect.	Heredity. Paternal.	Heredity. Maternal.	Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic Disease.	Onset and nature of mental disturbance.	Termination.
1	Consecutive.		Insanity, consumption, epilepsy.	2	2 wks.	Normal.	No change.	Uneventful.	None.	Two weeks after birth of child became depressed, developed persecutory ideas and threatened suicide.	Dementia.
2	Primary.	Insanity.	Consumption.	2	1 mo.	Normal.	Despondent.	Uneventful.	None.	One month after confinement became confused, depressed and developed persecutory ideas, followed by exaltation.	Dementia.
3	Consecutive.	Consumption.	Insanity.	2	1 wk.	Normal.	Irritable.	She was excited and nervous during puerperium.	None.	One week after confinement she developed auditory hallucination and persecutory ideas.	Dementia.
4	Primary.	None.	None.	4	10 wks.	Normal.	No change.	She was irritable after confinement.	None.	Two and one-half months after confinement developed persecutory ideas and attempted suicide.	Dementia.
5	Consecutive.	None.	None.	3	6 mos.	Post partum hemorrhage.	No change.	....	None.	Immediately after confinement developed auditory hallucinations, persecutory ideas; became incoherent.	Dementia.
6	Consecutive.	Alcoholism.	Insanity, cancer.	9	1 mo.	Normal.	No change.	....	None.	Soon after confinement developed auditory and visual hallucinations, persecutory ideas and religiosity.	Partial recovery.
7	Unstable.	?	?	2	15 yrs.	Normal.	Nervous and despondent.	Depression gradually passed away.	None.	Depression and depreciatory ideas during pregnancy.	Partial recovery.

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		Paternal.	Maternal.								
1	Consecutive.		Insanity, consumption, epilepsy.	2	2 wks.	Normal.	No change.	Uneventful.	None.	Two weeks after birth of child became depressed, developed persecutory ideas and threatened suicide.	Dementia.
2	Primary.	Insanity.	Consumption.	2	1 mo.	Normal.	Despondent.	Uneventful.	None.	One month after confinement became confused, depressed and developed persecutory ideas, followed by exaltation.	Dementia.
3	Consecutive.	Consumption.	Insanity.	2	1 wk.	Normal.	Irritable.	She was excited and nervous during puerperium.	None.	One week after confinement she developed auditory hallucination and persecutory ideas.	Dementia.
4	Primary.	None.	None.	4	10 wks.	Normal.	No change.	She was irritable after confinement.	None.	Two and one-half months after confinement developed persecutory ideas and attempted suicide.	Dementia.
5	Consecutive.	None.	None.	3	6 mos.	Post partum hemorrhage.	No change.	....	None.	Immediately after confinement developed auditory hallucinations, persecutory ideas; became incoherent.	Dementia.
6	Consecutive.	Alcoholism.	Insanity, cancer.	9	1 mo.	Normal.	No change.	....	None.	Soon after confinement developed auditory and visual hallucinations, persecutory ideas and religiosity.	Partial recovery.
7	Unstable.	?	?	2	15 yrs.	Normal.	Nervous and despondent.	Depression gradually passed away.	None.	Depression and depreciatory ideas during pregnancy.	Partial recovery.

Case Number.	Degree of defect.	Heredity.		Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
		Paternal.	Maternal.								
8	Unstable.	No history of constitutional disease.	No history of constitutional disease.	2	9 wks.	Normal.	Nervous and irritable during pregnancy	Normal physically.	Laceration of perineum, uterus retroverted. No symptoms.	Four days after birth of child confused, afraid, agitated, auditory hallucination and persecutory ideas.	Recovery.
9	Unstable.	No history of constitutional disease.	No history of constitutional disease.	1	5 wks.	Normal.	No change.	Puerperal infection followed by septicemia.	Vaginitis, pelvic tenderness, retro-displacement of uterus.	Two days after confinement became violently excited. Erotic and the subject of religiosity. Afterward developed persecutory ideas.	Recovery.
10	Consecutive.	No history One brother insane, another tuberculous.	No history	1 5 miscarriages	3 mos.	Difficult.	Irritable and despondent.	Severe post-partum hemorrhage.	None.	One month after confinement became depressed and the subject of religiosity. Afterward developed depreciatory ideas. Then became stupid.	Recovery.
11	Consecutive.	Father peculiar.	No history	4	4 mos.	Difficult.	Was apathetic, depressed and the subject of religiosity.	Normal physically.	Slight laceration of perineum and cervix, uterus retro-displaced and adherent.	After confinement became confused, incoherent; later depressed and agitated.	Partial recovery.
12	Unstable.	No history	No history	1	9 days.	Normal.	Despondent.	Normal physically.	None.	Three days after confinement became depressed. Two days later became violently excited and passed into delirium.	Recovery.
13	Primary.	No history	Neurotic.	1	6 wks.	Normal.	No change.	Normal physically.	Laceration of perineum and cervix. Purulent vaginal discharge containing blue pus bacillus and white staphylococci.	Two weeks after confinement became depressed, afraid. Afterward there were auditory hallucination, depreciatory ideas and religiosity.	Died. Chronic interstitial nephritis.

Case Number.	Degree of defect.	Heredity.		Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
		Paternal.	Maternal.								
14	Consecutive.	No history	Insanity.	2	....	Normal. Confined in hospital.	Depressed. Had depreciatory ideas with religiosity.	Normal physically.	Slight laceration of perineum. Subinvolution. Foul discharge containing Fränkel's pneumococcus.	After confinement she developed persecutory ideas.	Partial recovery.
15	Unstable.	No history	Insanity.	1	6 wks.	Normal.	No change.	Normal physically.	Laceration of cervix and perineum. Uterus retrodisplaced and adherent. Glairy disch'ge containing staphylococci.	She was stupid after confinement, and two weeks later developed depreciatory ideas. Became suicidal and homicidal. Afterward violently excited.	Recovery
16	Unstable.	Insanity.	Cancer.	5	6 yrs.	Normal.	Depressed and morose. Violent and homicidal.	Normal physically.	None.	During the 6th month; was depressed after coming to the hospital. Was confined one month after admission.	Recovery.
17	Unstable.	Consumption.	Insanity. Sister insane.	7	7 yrs.	Normal.	Excited and jealous.	Normal physically.	None.	Soon after she became pregnant, auditory hallucination, persecutory ideas and jealousy. She had been in the same condition during previous pregnancies.	Recovery.
18	Unstable.	No history	No history	4	18 mos.	Normal.	No change.	Normal physically.	None.	Was peculiar as a girl. After marriage had suicidal impulses. Was better mentally when pregnant. Soon after birth of last child became exalted, garrulous and incoherent.	Partial recovery.

Case Number.	Degree of defect.	Heredity. Paternal.	Heredity. Maternal.	Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
19	Consecutive.	Rheumatism.	Rheumatism. One sister insane.	10	4 mos.	Normal.	Irritable and depressed.	She suffered from septicemia.	None.	One month after confinement became depressed, developed depreciatory ideas, and had suicidal impulses.	Dementia.
20	Unstable.	Insanity.	No history	5	8 mos.	Normal.	Irritable and depressed.	Did not regain her strength.	None.	She has been more or less disturbed for 18 months, but after her last confinement became incoherent, suffered from insomnia, and finally became delirious.	Recovery.
21	Consecutive.	Neurotic.	Neurotic.	3	1 mo.	Normal.	Irritable and depressed.	Puerperal septicemia.	None.	Sixteen days after confinement became excited, violent, homicidal and suicidal; auditory hallucination and persecutory ideas.	Recovery.
22	Unstable.	Neurotic.	Cancer.	3	$4\frac{1}{2}$ yrs.	Normal.	No change.	Normal physically.	Subinvolution, leucorrhœa, staphylococcus albus.	Two weeks after birth of last child became depressed and agitated. Afterward excited and violent. These attacks have recurred from time to time since then, each one being more violent than its predecessor. After coming to the hospital she was delirious.	Recovery.
23	Primary.	No history	No history	4	$3\frac{1}{2}$ yrs.	Difficult.	No change.	Septicemia.	Pyosalpinx and cystic degeneration of both ovaries.	After the birth of the child developed religiosity and persecutory ideas, presently became worse, grew excited suicidal and homicidal.	Partial recovery.

Case Number.	Degree of defect.	Heredity.		Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
		Paternal.	Maternal.								
24	Primary.	Cancer.	Insanity.	1	3 wks.	Normal.	At the 6th month became nervous and excited; afterward developed persecutory ideas.	Normal physically.	None.	Was neurotic; as a girl practiced masturbation. During the last two months of her pregnancy she had auditory hallucinations and persecutory ideas. After confinement she developed depreciatory ideas and suicidal impulse.	Died. Pulmonary tuberculosis.
25	Unstable.	No history	Insanity. Mother, sister and cousin insane.	6	4 mos.	Normal.	Timid and afraid.	Normal.	None.	3 months after confinement became exalted, garrulous and incoherent.	Recovery.
26	Unstable.	Neurotic.	Insanity.	5	5 mos.	Difficult.	Irritable and depressed.	Did not regain her strength.	Laceration of cervix.	Three months after confinement religiosity, gustatory hallucination, persecutory ideas. Later, incoherent and delirious.	Recovery.
27	Consecutive.	No history Brother insane.	No history	10	11 mos.	Normal.	No change.	Normal.	Laceration of perineum and cervix. Retroversion of uterus and adhesions. Leucorrhœa, white staphylococci.	Four months after birth of child excited and incoherent. Gradually increased until she became violent. Similar attack with previous child.	Partial recovery.
28	Primary.	Cancer.	Neurotic.	3	6 wks.	Normal.	No change.	Normal physically.	None.	Five weeks after birth of child became hysterical. afterward violently excited. Grandiose ideas and religiosity.	Dementia.

Case number.	Degree of defect.	Heredity.		Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
		Paternal.	Maternal.								
29	Unstable.	Alcoholism.	No history	2	5 mos.	Normal.	No change.	Normal physically.	Laceration of cervix; ovaries tender; purulent discharge containing blue pus bacillus.	One month after confinement ill temper, persecutory ideas. Afterward confusion, incoherence, garrulity, violent excitement.	Partial recovery.
30	Unstable.	No history	No history	2	16 mos.	Normal.	Irritable and depressed.	Normal physically.	Retroversion and adhesion of uterus; endometritis and leucorrhœa. Discharge contains white staphylococci.	Nursed child 15 months. Mental disturbance followed the appearance of the menses. Depression, confusion, incoherence, persecutory ideas and homicidal tendency.	Recovery.
31	Unstable.	No history	No history	1	2 mos.	Normal.	Depressed.	Normal physically.	None.	Was unmarried and suffered from mortification on account of her condition. 2 weeks after confinement became violently excited, garrulous and incoherent. Auditory hallucinations.	Recovery.
32	Consecutive.	Consumption.	Consumption.	3	5 mos.	Normal.	Irritable and despondent	Normal physically.	None.	Irritability and depression. Grew worse after confinement. Two months after confinement developed auditory hallucination and persecutory ideas. Suicidal tendency.	Partial recovery.
33	Consecutive.	No history Brother epileptic and insane.	No history	5	5 yrs.	Normal.	No change.	Normal physically.	None.	After birth of first child developed persecutory ideas and religiosity. Never fully recovered, and had similar attacks after each confinement. Religiosity and depreciatory ideas persist.	Dementia.

Case number.	Degree of defect.	Heredity. Paternal.	Heredity. Maternal.	Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
34	Consecutive.	Alcoholism.	Insanity.	4	19 mos.	Normal.	Irritable and despondent	Normal physically.	None.	Immediately after confinement auditory hallucination and persecutory ideas.	Partial recovery.
35	Consecutive.	No history of constitutional disease.	No history of constitutional disease.	3	6 mos.	Normal.	No change.	Normal.	Laceration of cervix. General tenderness. Leucorrhœa containing colon bacillus. Hæmorrhoids.	Was insane after birth of first child. 2 months after last confinement became depressed, had depreciatory ideas and suicidal impulse. Auditory hallucination.	Recovery.
36	Consecutive.	No history Brother insane.	No history	2 Both stillborn.	......	Normal.	No change.	Normal.	Laceration of cervix. Subinvolution. Endometritis.	Became insane after confinement six years ago. Auditory hallucination. Persecutory ideas.	Dementia.
37	Consecutive.	Alcoholism.	Consumption.	1	1 year.	Normal.	No change.	Normal physically.	None.	She was depressed for some time after confinement. Apparently recovered, but two months ago became depressed. Afterward excited, violent, noisy and destructive.	Recovery.
38	Consecutive.	Cancer.	No history A sister insane.	7	2 yrs. 7 mos.	Normal.	Depression. Persecutory ideas. Suicidal impulse.	Normal physically. She was confined in the hospital.	Laceration of perineum and cervix. Leucorrhœa containing white staphylococcus.	About the sixth month of her pregnancy insomnia, confusion, persecutory ideas, disposition to wander about, and suicidal impulse.	Dementia.
39	Consecutive.	No history of constitutional disease.	No history of constitutional disease.	6	5 mos.	Normal.	No change.	Normal physically.	Uterus retroflexed. Left ovary prolapsed.	Four months after confinement religiosity, auditory hallucinations. Persecutory ideas.	Dementia.

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		Paternal.	Maternal.								
40	Consecutive.	Consumption.	Insanity.	13	7 mos.	Normal.	No change.	Normal.	Laceration of perineum and cervix. Retro-displacement and adhesions. Leucorrhœa B. Proteus.	She was insane for four weeks while nursing her first child. Three months after last confinement developed religiosity, depreciatory ideas, auditory hallucination and persecutory ideas.	Recovery.
41	Consecutive.	No history	Consumption.	2	2 mos.	Normal.	Depressed and despondent.	Normal.	Laceration of perineum. Uterus retroverted and adherent. Profuse leucorrhœa, white and yellow staphylococci.	Seven weeks after confinement became depressed, feared harm to herself, and had suicidal and homicidal impulses.	Partial recovery.
42	Primary.	No history	No history	1	5 mos.	Normal.	Irritable, nervous and depressed.	Normal physically.	Retro-displacement of uterus. Leucorrhœa B. tenuis.	Three months after confinement religiosity. Depreciatory ideas. Suicidal and homicidal impulse. Persecutory ideas.	Dementia.
43	Consecutive.	No history	No history	7	2 mos.	Normal.	No change.	Normal physically.	None.	Four days after confinement became excited, afterward developed religiosity, depreciatory ideas and disposition to seclusion.	Dementia.
44	Consecutive.	Cancer.	Consumption.	2	4 yrs.	Difficult.	Despondent.	Normal.	None.	Has been more or less insane since birth of first child. Visceral consciousness, Auditory hallucination. Persecutory ideas.	Dementia.

Case Number.	Degree of defect.	Heredity		Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
		Paternal.	Maternal.								
45	Primary.	Consumption.	No history	4	3 mos.	Normal.	No change.	Septicemia.	None.	Soon after confinement persecutory ideas, auditory and visual hallucination. Excited, homicidal.	Dementia.
46	Consecutive.	Alcoholism.	Insanity.	2	1 yr.	Normal.	No change.	Normal.	None.	Three weeks after confinement confusion, alternately excited and depressed; persecutory ideas; suicidal and homicidal impulse.	Dementia.
47	Consecutive.	No history Brother, consumption.	No history Cousin insane.	9	7 mos.	Normal.	No change.	Normal.	Laceration of perineum and cervix. Erosion of cervix. Retroversion and adhesion of uterus. Leucorrhœa, blue pus bacillus, pelvic tenderness.	Three months after confinement confused, suspicious, auditory hallucination, persecutory ideas.	Dementia.
48	Primary.	Alcoholism.	No history	1	....	Normal.	Depressed, stupid.	Normal, child born in hospital.	Vaginitis, endometritis and salpingitis. Gonorrhœal infection. Leucorrhœa.	Was an imbecile but became stupid, depressed and sullen after third month of pregnancy.	Dementia.
49	Primary.	Insanity.	No history	1	15 yrs.	Normal.	Peculiar.	Normal physically.	None.	Two days after confinement she wandered away and attempted suicide. Was confused and afterward stupid.	Partial recovery.
50	Consecutive.	No history Brother insane.	No history	7	8 mos.	Normal.	No change.	Normal physically.	Laceration of perineum and cervix. Leucorrhœa, B subtilis.	One month after confinement religiosity, depreciatory ideas.	Dementia.

Case number.	Degree of defect.	Heredity.		Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
		Paternal.	Maternal.								
51	Unstable.	No history Brother insane.	Insanity. 2 sisters insane.	7	3 mos.	Normal.	No change.	Normal physically.	Laceration of perineum and cervix. Leucorrhœa. B. Proteus.	Has been insane with two previous children. Six weeks after last confinement auditory hallucination, persecutory ideas, homicidal impulse.	Recovery.
52	Primary.	Cancer. Consumption.	Neurotic.	2	10 mos.	Normal.	Depressed. Jealous.	Normal physically.	Retro-displacement and adhesion of uterus. Leucorrhœa. Staphylococcus albus.	Was insane after birth of first child. Four months after last confinement auditory hallucinations, persecutory ideas.	Dementia.
53	Consecutive.	Consumption.	No history	1	3 yrs.	Normal.	No change	Normal.	Laceration of perineum. Leucorrhœa. White staphylococcus.	Has been depressed and suspicious ever since birth of child. During the past year has developed auditory hallucination and persecutory ideas.	Dementia.
54	Primary.	No history Brother insane.	No history	1	1 year.	Normal.	Depressed.	Normal physically. She was confined in the hospital.	None.	She was slightly depressed after the birth of the first child. Became depressed and confused after sixth month of present pregnancy. Confusion and persecutory ideas.	Dementia.
55	Primary.	No history Brother insane.	Insanity.	1	2 mos.	Normal.	Depressed. Despondent	Normal physically.	Laceration of perineum and cervix. Retro-displacement of uterus with adhesions posteriorly. Subinvolution. Leucorrhœa. Ovaries tender. Vaginitis. B. pyocyaneus. B. subtilis.	During the sixth month of her pregnancy became depressed, dull, indifferent; occasionally excited. After confinement developed visceral consciousness and persecutory ideas.	Dementia.

Case Number.	Degree of defect.	Heredity. Paternal.	Heredity. Maternal.	Number of children.	Age of youngest child.	Character of labor.	Mental condition during pregnancy.	Puerperium.	Pelvic disease.	Onset and nature of mental disturbance.	Termination.
56	Unstable.	No history	Insanity.	2	5 mos.	Normal.	Depression. Confusion.	Normal physically.	Subinvolution. Leucorrhœa. White staphylococci.	Two months before confinement confusion, indifference. Afterward persecutory ideas, destructive tendency and homicidal impulse. She had suffered from acute insanity three years previously.	Dementia.
57	Unstable.	No history	Neurotic.	4	20 mos.	Normal.	Confused, excited, incoherent.	Normal physically, child was born in hospital.	Pregnant. Laceration of perineum and cervix, also erosion. Leucorrhœa, B. coli communis.	In the third month of her pregnancy confusion, irritability. Incoherency, afterward excited. She had a similar attack five years ago.	Partial recovery.
58	Primary.	Alcoholism, insanity.	No history	1	7 mos.	Normal.	No change.	Normal physically.	None.	Soon after confinement became emotional. Disposed toward exaltation. Recently these manifestations exaggerated. Later violent acute mania.	Dementia.
59	Primary.	No history 3 cousins died—consumption.	Neurotic.	2	4 yrs.	Difficult.	No change.	Got up weak.	None.	About 7 months after confinement sexual excitement, persecutory ideas, auditory and visual hallucination. She is at times violent.	Dementia.
60	Consecutive.	No history	Cancer.	3	4 mos.	Difficult.	Nervous.	Suffered from pain and insomnia.	None.	Two weeks after confinement confusion, fear; afterward auditory hallucination, persecutory ideas.	Dementia.

Of the sixty cases included in this table, fifteen were primiparæ and forty-five multiparæ. Five of the multiparæ are recorded as having some mental disturbance after the birth of the first child; and in a number of the remainder, evidence since accumulated would indicate that there had been some aberration before the outbreak which brought the patient to the hospital. Five of the sixty women had more than two attacks of insanity; eight had two; while the remaining forty-seven had only one recognized outbreak of insanity. Twenty cases had an heredity of insanity; while in thirty-one there was either no record of constitutional disease in the family or else a history of alcoholism, epilepsy or cancer. In nine cases there was an heredity of consumption. Some of the patients in whose families there was an heredity of insanity also had a record of relatives suffering from consumption, and some had brothers, sisters or cousins the victims of phthisis. In twenty-nine of the women there was present some degree of pelvic disease; while the other thirty-one were free from physical disturbance of any kind and among those who had pelvic disease only three complained of discomfort or apparently suffered any inconvenience from their condition. In four cases the symptoms of mental aberration made their appearance during the first half of pregnancy, eight in the last half, twenty-eight during the puerperium and twenty at some time during the period of lactation. Thirty-seven of the women were depressed, seventeen were excited and six were delirious. Two had grandiose ideas, thirty-eight persecutory ideas, ten depreciatory ideas; thirteen were the victims of religiosity and four of sexual excitement. There was auditory hallucination in twenty-four cases, visual in three, gustatory in one and visceral consciousness in two cases. Ten were homicidal and fourteen were suicidal. Of the sixty cases eighteen recovered, thirteen partially recovered, twenty-seven lapsed into dementia and two died. Of those who lapsed into dementia eleven were primary degenerates; that is, they became insane during adolescence. Fifteen were consecutive degenerates; that is, they became insane during adult life. One is classed as unstable, but the outbreak of insanity occurring in connection with maternity was the second from which she had suffered. Of those who partially recovered four were unstable, seven consecutive and two primary degenerates. Of those who

recovered five are classed as consecutive, because the outbreak of insanity connected with maternity came during adult life and left a certain degree of mental reduction behind it. In none of the cases did the form of mental disturbance remain the same throughout the attack. Those who were depressed in the beginning were afterward excited and the excited ones became depressed. All of them were more or less confused at first, and in those cases where the patient did not pass directly from confusion into delirium, there was gradually evolved the sense perversion and the resulting belief which determined the excitement or depression by which it was accompanied. In a certain number of cases mental reduction was so rapid and complete that the conduct of the individual was automatic, with the primitive characteristics instinctive in the child. Religiosity, as is usual, was accompanied by exaltation or depression, according with the presence of grandiose or depreciatory ideas. Sexual excitement occurred in those cases where there had been no normal sexual appetite before the outbreak of insanity. Of those who recovered four had an heredity of insanity alone and two of both insanity and consumption; while in one the heredity was consumption alone. Two had a neurotic heredity and nine furnished no history of constitutional disease in the family. Of those who partially recovered three had an heredity of insanity, two of consumption, one neurotic; while six furnished no history of constitutional disease and one had a family history of alcoholism, cancer and insanity. Of those who became demented three had an heredity of insanity, seven of consumption, one neurotic, four of cancer, one of alcoholism, one of rheumatism and ten furnished no history of constitutional disease in the family. Of those who became insane during the first half of pregnancy, three were unstable and one was a primary degenerate. In the second half, three were unstable, one a consecutive and three primary degenerates. Of those becoming insane during the puerperium, six were unstable, sixteen consecutive and five primary degenerates. Of those becoming insane during the period of lactation, three were unstable, ten consecutive and six primary degenerates. Of those who recovered one became insane in the first half and one in the second half of pregnancy, nine during the puerperium and seven during the period of lactation. Of those who partially

recovered, one became insane in the first half, one in the second half of pregnancy, seven during the puerperium and four during the period of lactation. Of those who became demented, one was insane during the first half, four during the second half of pregnancy, ten during the puerperium and twelve during the period of lactation. This proportion corresponds with my general experience outside of this particular study—the chance of recovery in any given case of insanity connected with maternity being greater the earlier in the cycle the outbreak occurred, and paradoxical as it may seem, the more defective the individual is mentally, the later the insanity will manifest itself; while the fact that the largest number of women become insane during the puerperium is explained by the greater strain of the act of parturition upon the nervous system and not in my experience to septic infection or intoxication. The period of lactation while not so strenuous is persistent and for that reason affects the mentally weak most and marks the onset of reduction and aberration in the progressively degenerate cases. Of course we have to bear in mind that degenerative changes may and commonly do exist for a long time before they are appreciated; just as mental reduction is often considerable before it is recognized; the changes in the character and conduct of the individual being attributed to anything but the real cause. This is especially liable to occur in connection with the insanity associated with maternity; because domestic tradition makes those familiar with the individual expect some departure from the normal and usual habits and behavior of the woman. I have never found anything peculiar or distinctive in the manifestations of mental aberration associated with maternity. It is true that more women recover who become insane in connection with maternity, and this is especially true of the large number of cases which for obvious reasons are not committed to hospitals for the insane. I have been surprised in studying the case records in this hospital to find that outside of the degenerations taking place during the period of adolescence, the climacteric, and in senescence, the insanity of the rest of the women is practically always in some way related to maternity. It is not surprising when we consider the marked influence of pregnancy and maternity upon the life processes in the woman and the demands they make upon the nervous system, especially

in primiparæ, that any instability or defect should become conspicuous, or that if the former be marked the nervous system should be unbalanced; while in the latter the strain should be the starting point for the degenerative process. I have under my care a woman, the mother of seven children, who was insane for a time after the birth of each child, the attacks being more prolonged and the mental reduction greater each time, and such cases are not uncommon. There are very few women who do not suffer from depression and irritability during pregnancy, and perverted appetite is quite common; while some, even where there is no other manifestation of aberration, will suffer from perversion of some one of the special senses, usually in the form of olfactory or gustatory hallucination. Then there is the morbid self-consciousness and the different forms of unreasoning fear, jealousy, suspicion and emotional outbreaks. Now if these disturbances occur in the average woman it is not surprising that they should be exaggerated in the unstable or become the starting point for progressive degeneration in the defective. That it is the shock or strain alone which provokes the outbreak of insanity in the pregnant or parturient woman is negatived by the fact, before referred to, that from a physical standpoint the history of the period of gestation is uneventful, the labor is as a rule normal, and while the table shows a certain number of cases in which there was pelvic disease, there is no evidence that the insanity was in any way related to it. In the simplest form of puerperal insanity there is usually only the addition of confusion and loss of control to what are considered the ordinary nervous disturbances associated with pregnancy. In others the patient passes from confusion into delirium and this is the commonest form of mental disturbance associated with the puerperal state which is recognized as insanity. As a rule those women who have been despondent during the period of gestation and are afterward insane, become excited; while those who have been irritable, hysterical and exalted, become depressed. In some cases, instead of recovery the delirium subsides into maniacal excitement, or the patient who is depressed becomes suicidal or manifests homicidal impulse toward the child. Again she becomes the victim of religiosity, with grandiose or depreciatory ideas which govern her conduct; or she may develop auditory hallucination, to be followed by persecutory

ideas. Sometimes there is simply progressive mental reduction, with the furtive suspicion, obstinacy, and explosive outbreaks of violence characteristic of the animal. Of course there are infinite variations in these manifestations, but whatever form the disturbance assumes it will be found to be related to a definite degree of defect in the individual; the simplest form of mental disturbance being associated with brain instability, while the graver forms are associated with defective development and are proportioned to the degree of defect as shown by the heredity and corresponding limitation of cerebral potentiality. The most important consideration in connection with any given case of puerperal insanity is the prognosis; and here is where it becomes necessary to appreciate the third element in the equation. The history of the cases recorded in this paper and of one hundred and fifty others, from among which they were selected, would indicate that the prognosis in any given case of insanity connected with maternity was dependent upon the heredity of the patient; and further that those cases having an heredity of insanity alone are most likely to recover; while those having an heredity of consumption, alcoholism, syphilis, or cancer, are the most certain to be the victims of progressive degenerative changes. Or to express the same conclusion in another way: The children of the insane are unstable, but the children of those suffering from somatic disease which seriously impairs vitality are defective.

THE RÔLE OF WOUND INFECTION AS A FACTOR IN THE CAUSATION OF INSANITY.

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The introduction of the microscope in the minute analysis of pathological tissues and in the discovery and differentiation of atomic germs is rapidly revolutionizing the etiology of disease. The patho-bacteriologist, by his researches, has shown how prominent a factor the micro-organisms are in causing the many physical ills that affect and decimate the human race. Furthermore, we are beginning to estimate the potency of these organisms and their products in the frequent production, directly or indirectly, of many cases of mental alienation.

The Germs of Wound Infection.

The bacteria usually found in wound infections:

1. The streptococcus pyogenes,
2. The staphylococcus pyogenes,
3. The micrococcus gonorrhœa,
4. The streptococcus of Fehleisen,
5. The saprophytes.

There are other bacteria occasionally found in wounds, but the above-mentioned are the germs mostly concerned in wound infection.

Not only do the bacteria themselves act as a virus, but their chemical products—toxine and ptomaine—possess a specific virulent action when absorbed into the body.

Wounds Usually Infected.

1. Small abrasions, or incised wounds, or contusions on the face or on the scalp, usually subject to neglect.

2. Lesions of the genital tract entailed by maternity, such as

perineal tears, bruising and contusions of the vagina, laceration of the cervix uteri, and the raw placental site in the puerperal uterus.

These wounds are the favorite portals through which the germs or their virulent products find entrance into the lymphatic or circulatory channels and thence distribute themselves throughout the system.

Effect of Infection Upon the Constitution.

Action of infection upon the central nervous system is brought about directly through its circulation. The contaminated blood filtrating through the capillaries is absorbed into the cellular and ganglionic structures, bringing about abnormal changes in their protoplasmic elements, varying from cloudy swelling to distinct pigmentation. These noxious elements disturb the harmony of their exquisitely balanced functions, interfering with the infinitesimal chemism so necessary to the production of rational action and thought.

The indirect action of the infection upon the central nervous system occurs through the disturbance of the organs engaged in the digestion of food by the toxic material. The effect on these organs is to lower the nutritive qualities of the ingesta and therefore the blood plasma, upon which the brain, like all organs, is dependent for the maintenance of its vitality. Also the infected blood current, circulating through the capillaries of the vaso-motor centers, irritates these centers, and disturbs through them the equilibrium of the cerebral circulation thereby enhancing the intoxication already produced in the centers of thought and reason. Furthermore, if in the infected patient there exists a prior condition of heredity, the effects of the toxemia are intensified. Is it, then, to be wondered at that such a delicately poised organ as the brain should show the various phases indicative of mental disquietude, ranging from hebetude or delirious muttering to the intenser or graver forms of melancholia and mania?

Effect of Infection Locally.

The effect of infection locally upon the wound or the tissues in its immediate vicinity is governed by the locality of the injury.

Superficial wounds of the body, especially of the face and head, are easily amenable to treatment and, as a rule, resolution of the wound is rapid and complete. Injuries, however, of the genital tract, from its situation, and especially if located in or on an organic structure, are more diffi ult of amelioration. Pathological processes in uteri often embrace the whole organ, owing to its extreme vascularity, and by extension or penetration may easily implicate the adnexa, or other pelvic contents. Thus, to the burden of infection in puerperal cases, are added inflammatory lesions, which often of themselves wreck the future health of the individual.

The Insanities Following Infection.

1. *Erysipelatous insanities.* A study of eight cases of insanity traced to the infection of the streptococcus of Fehleisen shows that the insanity may occur during the attack of erysipelas, or may follow the subsidence of the infection. They were all of the maniacal type, ranging from mild, paroxysmal mania to acute, violent mania, and which in some cases merged into a condition of chronic mania. Three, who became insane during the attack, recovered, one mentally improved, one died three months after the attack, and the remainder became chronically insane. None of the types of erysipelas in these cases were of phlegmonous nature, and the local inflammation made the usual resolution.

2. *The Septic Insanities of the Puerperium.*

The septic insanities of the puerperium embrace a larger field. For convenience they may be described under three heads:

A. *Puerperal insanity, with little or no local lesion, caused by septic infection.*

The insanities from this origin occur probably from absorption into the circulation of the toxines of an infected clot, either through the placental site or some tear or abrasion, or by the absorption of the ptomaines of the saprophyte germ, which find lodgment in the detritus of a puerperal uterus.

The majority of these cases being of short duration recover at their homes on elimination of the poison. They are usually of a mild confusional type or a form of muttering delirium.

B. *Puerperal insanity complicated by gross local lesion, the result of septic infection.*

The insanities of this class are usually of a more serious character than those of the former. The local inflammatory lesion acts as a focus, keeping up the prior intoxication by distributing a continued supply of the virus to the already poisoned circulation of the patient, or by reflex irritation. The majority of these patients do not recover their normal mental condition under ordinary systemic treatment.

The study of the histories of ninety-eight cases admitted into the London Asylum since the year 1870, in which the alleged cause was given as the puerperium, discloses that just one-half, or fifty per cent., recovered reason. It is fair to suppose that very few of these had any serious local lesion complicating their insanity, as some recovered very soon after their admission. I have been able to examine gynecologically twenty-three of these ninety-eight cases. In twenty-two of them were lesions ranging from subinvolution to complete agglutination of the pelvic organs. This would indicate that over ninety per cent. of these cases had some complicating pelvic lesion. Suitable surgical measures being adopted in twenty-one of these, resulted in the mental recovery of eight cases and in the improvement of four, while nine remained unimproved. The eight recoveries were included in the fifty per cent. before-mentioned total recoveries in the puerperal cases.

I may say that seven of the nine who failed to show any mental improvement subsequent to surgical treatment had been insane for periods of from two to sixteen years.

C. *Post-puerperal insanity, induced by pelvic disease, the latter being the result of septic infection.*

It is now generally recognized by obstetricians and gynecologists that a severe local sepsis may occur in the genital tract during the puerperium with apparently little systemic disturbance. This condition often escapes the notice of the accoucher, and as a result of which a prolonged and partial convalescence only ensues. The puerperal woman, on leaving her bed, has a constant feeling of malaise. The combination of pelvic disease, the main factor in causing the incomplete convalescence, together with the futile attempts to perform the duties of a wife and mother, ultimately result in a complete breakdown mentally and physically. This unfortunate sequela to the puerperium often occurs

six, eight, or ten months, or even longer after the birth of a child, and which can be traced back to its puerperal source. Unfortunately, however, the physicians who fill and sign the commitment papers, either are not in possession of the patient's previous history, or they fill out the forms very carelessly, giving very few, if any, facts of the prior health of the patients to be admitted. Alleged causes, like overwork, mental strain, or worry are usually assigned as the exciting factor, and in many histories a negative answer only is given. For these reasons I think it imperative that the history papers when issued for the admission of an insane woman to an asylum should have attached a slip containing certain leading questions, bearing upon the reproductive organs, to ascertain a fuller and more satisfactory history of the previous health of the patient in this respect. We would gain additional and valuable information which is rarely given in the usual insanity certificates. If the history then pointed strongly to the presence of lesions in the genital tract, and such be demonstrated, timely and invaluable treatment could be adopted and mental and physical recovery very much accelerated.

During the past four and a half years, we have at the London Asylum, endeavored to secure from the friends of the incoming female patient and the family physician, an account of the previous diseases (if any) the patient suffered from, and especially all the facts concerning the number of children and the history of the different puerperiums. Having this information at hand, we are then able to decide whether or not to make a gynecological examination of the insane woman. We have, to date, examined one hundred and eighty-seven women—recent admissions and chronic patients—and found distinct pathological lesions in one hundred and sixty-three. Of the one hundred and sixty-three there were no less than eighty who had inflammatory lesions of the pelvic organs that were, so far as we could judge, brought about by septic invasion at the time of a puerperium. All of these eighty women had marked subinvolution or chronic metritis, and forty-two had complicating diseased cervices. Some thirty-three had retro-displaced uteri, and nineteen had more or less seriously lacerated perinei. In addition, eleven had inflammatory tubal or ovarian disease, three had fibroid tumors, and one a deep rectal fistula.

Subsequently, upon suitable surgical treatment of these eighty cases, we had a return to physical health in nearly all, and thirty-six—or forty-five per cent.—recovered mentally, and twenty—or twenty-five per cent.—had mental improvement, while the mental condition of the remaining twenty-four—or thirty per cent.—remained stationary.

From this it is evident that if septic infection is mainly responsible for the production of inflammatory conditions of the pelvic organs occurring during the puerperium and that so large a percentage of mental recovery and improvement succeeded the removal of these lesions, it strongly emphasizes how important a factor the micro-organism is in thus directly or indirectly being the cause of many a case of mental alienation. Moreover it teaches these lessons, that too great care cannot be adopted by the accoucher in conducting a female through the really dangerous period of the puerperium and in protecting her from possible sepsis; and to those having the care of the female insane that the removal of inflammatory lesions of the pelvic organism when found, opens up a possible avenue of escape from mental thraldom to these unfortunate exiles of humanity.

THE DESIRABILITY OF CLOSE CONNECTION BETWEEN THE PSYCHOPATHOLOGICAL LABORATORIES AND HOSPITALS FOR THE ACUTE INSANE.[1]

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The proposition contained in the title of this paper would appear to be so self-evident as to require no special advocacy; but true as I believe the proposition to be, the facts, as they exist, are, that only to a limited degree are our psychopathological laboratories closely associated with hospitals for the acute insane, at least in this country. But this lack of association is not so much the result of a disbelief among medical men in the desirability of their closer union, as it is of certain physical conditions, which have made their direct connection difficult. The principal cause of this disassociation is the remote location of the hospitals with large aggregations of the insane, from the centers of population, and also from educational centers. Great medical schools are in large cities, and are centers of active study, which naturally draw to them the class of investigators best able by their tastes and acquirements to conduct original research. So it results that the schools and the laboratories group themselves together in the cities, while we find the hospitals for the insane and their staffs of physicians more remote.

It is not difficult to understand why the great hospitals for the insane are far from the centers of population. For the mass of the insane, as also for the crowded cities, there would be obvious disadvantages in their close proximity.

In the beginning there could have been no well-defined opinion as to the best locations for asylums and hospitals for the in-

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sane, and whatever belief was held has undergone various fluctuations in the course of years, and with increasing experience.

Within modern times, when the insane began to be gathered together from the streets and roads and waste places where they had wandered, they were, no doubt, usually placed in such convenient buildings and locations as already existed. When the monasteries and convents were confiscated in some countries, as in England, and their former occupants scattered abroad, some of these buildings were taken for the insane, as in the case of the Bedlam, now Bethlehem Asylum, in London. In those early times, these convenient places were generally in the suburbs of the cities, then much smaller than now; but gradually they lost their suburban character, as the cities grew about them, and the injury they inflicted on property interests and the public comfort in the growing neighborhood, and also the disadvantages suffered in many ways by the institutions themselves by this crowding of neighbors, led to the establishment of newer asylums, and the removal of some of the older ones to places distant from the centers of population. Owing to the natural tendency to go to extremes, in moving institutions to the surburbs, in some instances, they went far out into the country, and considerable time is required to reach them from the nearest city. Various considerations determined the sites of new hospitals, such as their being elevated, and presenting a commanding appearance; having sufficient pure water; being in a central situation in regard to some district from which their inmates were to come, and having a considerable area, where land was not too expensive. A feeling that seclusion and freedom from intrusion are desirable for such hospitals, and that employments may be arranged upon the land, and be both beneficial to inmates and economical in the administration, has also influenced this centrifugal tendency of institutions.

From this distant location of great numbers of the insane, it results that in most cases, they are far removed from the medical schools, which, for their success, require an exactly opposite condition of location from that governing the placing of great hospitals for the insane. While didactic instruction may be given anywhere, medical instruction needs so distinctly to couple example with precept, that a school teaching of general diseases and their treatment, must be where instances of these diseases

are numerous, and the opportunities to observe their course and treatment are easy, where not too much time is consumed in going from the lecture room to the bedside clinic. Any one who has experienced the facilities for economizing time in post-graduate study at such a hospital as that at Vienna, where everything is within easy reach, and where the students can go from lecture to lecture, and from one practical demonstration to another with little loss of time, and has then experienced the opposite condition of things, as in London or Paris, where hospitals are scattered all over the cities, and everything occurs at about the same time, will realize the greatly increased fatigue and waste of time under the latter conditions, and the great advantage of the proximity of the hospitals for various diseases, with their operations, and bedside clinics to the lecture rooms. If this waste of time is great in the study and observation relating to general diseases, where the special hospitals are widely scattered, how much more so is it when the material for exhibition in the great hospitals for the insane is miles away from the usual resorts of the medical students. No doubt examples of many forms of insanity may be brought to lecture rooms, but many other equally interesting varieties of the disease are in their nature as unfit for such a journey from a distant hospital to a lecture-room exhibition, as would be cases of typhoid fever or other acute general disease.

In the matter of treatment, students limited to didactic instruction alone, in this form of disease, while they may gain much theoretical knowledge, must lose much of the equally, if not more, important advantage of experience and observation, and personal familiarity with instances of the various forms of insanity, about which they may have heard lectures, and taken notes in the lecture rooms. There would seem to be as little necessity to insist on the value of clinical instruction in insanity, as upon the proximity of hospitals and laboratories; but in effect to-day, the ordinary undergraduate in medicine is almost entirely unfamiliar with insanity from a personal study of instances of the disease; and yet so common is the affliction, that a doctor in general practice cannot avoid having in the first instance to see and advise in insanity cases. Among the members of the families he ordinarily treats for general diseases, one begins to show symptoms of insanity; the friends rely on the family physician for advice in

all their sicknesses, and they go to him in their need in this instance. Can there be any question that he should be able to meet the emergency, at least with some safe and tentative advice? But how can he be the refuge of the newly and strangely afflicted family, if he cannot tell whether the patient has paresis, with a tendency to waste his means, and plunge his family in want; or has paranoia, and may kill a fancied enemy, or that his disease is such, that it is a safe case to retain, and treat at home? On the advice of the family physician may depend the prompt diagnosis of a case of insanity, and the adoption of early and effective treatment. How important then, that the medical student should see something of mental disease as part of his necessary course of study, before he is permitted to begin practice, and assume responsibility in such cases.

Having briefly referred to the feature of the distant position of most hospitals for the insane from medical centers, and to the great advantages to students of medicine, that they should have ample opportunities to observe all forms of insanity, we still realize how great are the practical difficulties, when distance, that great consumer of time, stands between them and their clinical opportunities. But the hospital for the insane, and the neighboring medical schools are only two of the elements of an ideal combination, and the third element is the laboratory for the investigation of all the multitudinous manifestations of mind, rational and irrational, the complete master of itself, or the crippled and disjointed remnant of a degenerate stock.

As the mortuary room furnishes the material for the pathologist, so does the hospital for the insane furnish much material to the psychopathologist. Like the physiologist, he must also study normal life; but nothing in the fact of close proximity to insanity prevents the widest range of study into normal psychology.

Within a comparatively recent period, laboratories with a distinct purpose of studying mind as an entity nave been established in various places, and in these new workshops capable investigators are weighing and measuring the various phenomena of the sensory organs, their acuteness and quickness of response to excitation, the mechanism of impressions and registration and subsequent ideation, etc., etc.

In Germany in particular, I am advised that almost without

exception every university town has in connection with its medical school a psychiatric clinic in close touch with a collection of insane patients, sufficient in number to serve the purpose of instruction. In these small hospitals the residence of the patients is comparatively short, but for clinical purposes long enough; and for observation in connection with laboratory work it seems to be indispensable.

It would seem that in this country, perhaps peculiarly, we must look to the laboratory with its organization and its elaborate apparatus for important results. Unless a private physician possesses a competency when he graduates, his necessities usually compel him to turn his efforts to making a living. In his early years, while waiting for patients, good judgment leads him to devote much of his enforced leisure to such laboratory or clinical or dispensary work as he can get access to without infringing upon his office hours; but as more and more patients call upon him for his services, and as perhaps his classes in some under- or postgraduate school demand about all the time he can spare from his business, his excursions in the fields of original work grow less and less systematic and productive of valuable results. This fact is well realized in pathological work in general and hence the laboratories for investigation, other than into the phenomena of mind. Here the conditions are most favorable. Capable men, every appliance, and the wealth of materials from surrounding hospitals make these special laboratories the centers of serious and valuable work.

When we observe the circumstances surrounding the workshops of the pathologist, the physiologist and the chemist, who have at hand everything which enters into their work, and offer every facility to students of medicine to follow particular lines of study, and then realize how our psychopathic laboratories are crippled by their necessary distance from the material, we must fear they cannot but fail of the highest expectations entertained of them.

Individual efforts have made many valuable additions to the knowledge of insanity and the general scope of mind; but from individuals disassociated and with many limitations, we can hardly look for grand results; but what may we not hope from a psychopathic institute liberally sustained and amply furnished,

where every vital problem can be followed to its elements, and where every phase of normal or diseased mind may be observed conveniently and exhaustively?.

The completeness and consequently the perfect efficiency of such an instrument of investigation—a psychopathic laboratory—would seem to depend on its being in the nearest relations to the materials to be investigated; and unless it is near a hospital containing patients, to whose diseases the laboratory is, if not wholly, certainly in a vital manner, related, it would seem to be deprived of one most important element of usefulness and success. In other countries about the medical school and the various laboratories are gathered the patients, not only those suffering with general and special diseases, but also enough recently insane persons to make the hospital a complete collection of all the diseases the future doctor may have to treat, or the present investigator may wish to observe.

In this greatest city and most important medical center of the country, where almost everything which experience has taught to be valuable for the purpose is within reach of the student, is it too much to hope that we may ere long have a good and sufficient hospital for the temporary home of such dependent persons as become insane within its limits, in close touch with our noble psychopathic institute, and not too far removed from the schools for the students to get to it easily and often?

With such a conjoint establishment, the medical student could get such practical knowledge of insanity as would rob him of the timidity and uncertainty which to some extent prevails among general practitioners when suddenly called to attend such cases. The professors of psychiatry would have a field worthy of their best efforts. The psychological laboratory would have a wealth of material, which it would wisely utilize, and recently and temporarily insane patients would have the best and earliest application of such valuable remedial discoveries as might be there administered in a truly scientific as well as in a charitable spirit; and lastly, from such a center of medical knowledge would be disseminated an incalculable benefit among the widely scattered hospitals for the insane, which are necessarily located in distant communities, and are looking eagerly for any new thing which will enable them to minister more wisely and well to the afflicted under their care.

SOME DIFFICULTIES IN THE RETRACTION THEORY.

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The unqualified acceptance of the so-called Retraction Theory of the propagation of nervous impulses by such men as Van Gieson [1] and Sidis [2] must commend it to the serious consideration of all who are interested in such subjects. I wish to call attention, briefly, to some difficulties in the way of accepting it as an adequate account of the physical basis of the changes of consciousness in health and disease, which I do not remember to have seen mentioned in my reading on the subject.

As I understand the hypothesis, it assumes that all nervous reactions, whether mental or physical, are conditioned by the formation and interruption of contact between different groups of nerve-cells by means of the protrusion or retraction of the terminal filaments of their neuraxones. Sidis says: [3]

"Groups of nerve-cells with more or less stable functions become gradually organized and form a stable organization. The more complex, however, a system of nerve-cells is, the greater its instability, and in the very highest systems or constellations of clusters the instability reaches its maximum. The instability of a system is in proportion to its complexity. In the very highest constellations the instability is extreme, and there is going on a constant process of variation. Under the action of the slightest external or internal stimuli, such unstable systems or constellations lose their equilibrium, dissolve and form new systems, or enter into combination with other constellations. On the psychical side we have the continuous fluctuation of the con-

[1] Archives of Neurology and Psycho-Pathology, I, 117.

[2] The Psychology of Suggestion, Chap. XXI.

[3] Loc. cit., p. 210.

tent of attention. The characteristic type of psychophysical life under the ordinary stimuli of the environment is a continuous process of association and dissociation of constellations."

It seems fair to infer that the writer's view is, not only that when an object of thought is present to our minds, the necessary connections are made, but also that whenever it is not so present, the connections are interrupted. If this is a correct interpretation of the theory, it would seem to follow that, at any given time, the immense majority of the terminal filaments in the cerebrum must be retracted, and it would, perhaps, be more appropriate to speak of the hypothesis as one of protrusion, than of retraction.

Here, it seems to me, a difficulty confronts us in endeavoring to picture the process of making the connections. The rapidity of our mental processes is such as to make it evident that these hypothetical movements must be accomplished with very considerable rapidity. Now, so far as I am aware, throughout the animal kingdom, movements of protrusion, properly so-called, that is, such as are not the indirect results of contractions, are slow movements. I do not recall anything analogous to the sudden projection of the terminal fibrils of the neuraxone which would be necessary under this hypothesis, when, for instance, we see an object of which we had not been previously thinking and instantaneously recall its name.

Again, the power of selection which must, on this hypothesis, be ascribed to the nerve-cells, is hardly credible. When I see my friend, John Smith, for instance, near at hand or at a distance, in front or in profile, stationary or moving, it is evident that the elements of the retina affected, and the manner in which they are influenced, are different in each case. Probably in all my acquaintance with him, I have never had two identical sensory impressions. Yet, under all these diverse conditions, these different cells, variously stimulated, are able, with unerring precision, to make the connections involved in the recollection of his name, residence, occupation, character, and all the various items that contribute to my conception of the man.

The theory under discussion has been thought to throw light on the phenomena of hysteria, such as hysterical anæsthesiæ and paralyses. It is supposed that, in such cases, there is, owing to contraction of the neurons, a temporary anatomical solution of

continuity in some of the connections involved in the sensation or movement, as the case may be. Thus, in the case of an hysterical amblyopia, the loss of consciousness of what is seen by the affected eye would be due to an actual interruption of some of the normal paths of conduction.

Now, in regard to this particular condition, a phenomenon has been repeatedly observed, and is mentioned by Sidis himself,[1] which seems to me impossible of explanation on this hypothesis. When a patient, thus affected, is made to look into the apparatus of Flees for the detection of simulated blindness, in which, by an arrangement of mirrors, only one object can be seen by each eye, and that seen by the right appears situated to the left of that seen by the left eye, she sees only that which is visible to the amblyopic eye. Thus, if the right eye is the one affected, she will see only the object apparently situated to the left, which is, in fact, invisible to the left eye.

It will be noted that, in such an experiment, the subject does not know whether she should see one object or more, or what the relative positions of the objects seen should be. On the supposition that there is an actual interruption of connections, the patients should see only one object, namely, that which is visible to the left eye, and, having nothing with which to compare its position, would have no reason to suppose that she saw it with the other eye. Why, under such circumstances, should there be a reversal of the connections and interruptions previously existing?

The foregoing are examples of the difficulties which I meet in endeavoring to apply the theory in detail to any given case. As there is no apparent possibility of an ocular demonstration of its truth or falsity, it would seem that it must stand or fall according to the completeness with which it accounts for the phenomena. So far as I am able, at present, to see, it creates more difficulties than it removes.

[1] Loc. cit., p. 94.

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TREATMENT OF THE SICK AND INSANE IN PERSIA.

By JAMES P. COCHRAN, M. D.,

Urumia, Persia.

It is difficult for those who reside in Christian and civilized countries, to conceive of large kingdoms, with established governments, and no little outward show of power and wealth, absolutely destitute of provision for their sick and insane, their orphans and paupers, their lepers and idiots, their inebriates and criminals; and yet this is true of Persia.

Aside from four hospitals erected by, and largely supported by, Foreign Missions, there is but one small one at Teheran, the capital. These hospitals treat only acute medical and surgical cases, and of course can supply the demands of but a small fraction of the needy. Lepers beg on the highways and are not permitted to enter the towns; idiots remain in their homes with the rest of the family and mingle with the children of the village or town; paupers, old and young, beg from door to door; cripples drag out a weary existence, basking in the sunshine, or sitting beside the oven, which is a well in the ground, and dangling their feet into it for warmth. Criminals dodge the law while they can, or pay fines and get flogged on their soles or have a hand or an ear or nose cut off, when caught. For the greater offences, they are strangled, or have their heads cut off, or are shot off at the mouth of a cannon.

There is no such thing as medical science as we understand it in the West. The Persian native doctor does, however, base his practice largely on the earliest Greek theories. He holds that there are four elementary constituents of the body. The excess of any one of these produces its special chain of diseases. When any one of these elements: blood, bile, phlegm and black bile (the element which produces all skin affections) is in preponderance, the physician's aim is to diminish it by direct means as well as by restricting the food to those articles which are believed not to produce that particular element.

In addition to this, there is much empirical prescribing. For croup, a child's forehead is scarified, and, if possible, a turtle is held in front of the patient's mouth and tormented till it sticks its head out and hisses or breathes into the child's throat.

For certain forms of swellings a frog is cut in two and bandaged over the part.

For jaundice, a few ounces of a child's urine are administered, in addition to dieting and remedies to produce biliary discharges from the bowels. The surgeons are absolutely ignorant of anatomy, and the knife is scarcely used for anything but superficial abscesses. When some deep affection must be reached, as caries or necrosis of the bone, the part involved is denuded, gradually, by caustics.

In general, and especially in compound fractures and bullet wounds, water is considered dangerous, the pus being simply wiped off daily. In the earlier course of the trouble, a fresh, warm skin of a kid tied over the part is considered the best treatment, as is proven by the profuse and malodorous pus which "it extracts from the seat of trouble"!

Median lithotomy is practiced some.

Inflammatory diseases of the eye are treated with powerful caustics, freely applied. Couching for cataract is practiced in places.

For the insane, and all suffering from striking nervous symptoms, medicine is considered of but little value. Here spirits or devils are manifestly present, and to treat these genii something more spiritual than ordinary materiæ medicæ must be used. There is a class of Persian physicians, called "prayer doctors," which will write prayers or quotations from the Mohammedan sacred books and sell them to the sick. For those possessed of a devil (any form of insanity, epilepsy, chorea, etc.) one of the first things to try is to get from a prayer doctor the first chapter of the Koran, written seven times, with musk and saffron on the inside of some vessel, after which it is to be washed off with pure water, and this is given to the patient to drink. If this fails, a little yarn that has been spun by a young girl is taken and a seven-fold cord is made with it. The ninety-eighth chapter of the Koran must be read seven times and then this cord is knotted and fastened to the arm of the patient. There are many Nestorian Christian

churches whose departed saints, after whom the churches are named, enjoy the reputation of curing these diseases. Even the Mohammedans frequently take their sick to these churches, carrying as an offering a lamb or a sheep, which is sacrificed to the saint, and the patient is locked up for a night in an underground dungeon built for the purpose. It is a fortunate thing that insanity, relatively, is much less frequent than in America, for after the friends have used such means as these described, or others of like value, the patient is allowed to wander where his genii lead, sometimes violent, and again perfectly harmless, sometimes clothed and often entirely nude, followed and taunted by the boys and girls of the towns. Where these patients are known to be very dangerous, they are usually chained to some pillar or post in the house or stable, and remain there till death ends their misery.

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PROGRESS IN THE CLINICAL STUDY OF PSYCHIATRY.[1]

By EDWARD COWLES, M. D.,
McLean Hospital, Waverley, Mass.

In speaking of the clinical work at the McLean Hospital, it is not my intention to claim that progress has been made, but rather to present some reasons for our hope of progress. Being unable, for want of time, to prepare a written paper, at the request of the Secretary, for this meeting of the Association, the privilege has been granted me of making some informal remarks upon what is now being offered us that is new in psychiatrical study. Those of us who have learned our psychiatry during the last thirty years know how the earlier views that were handed down to us have prevailed and still hold us to the ideas of the acute psychoses that have so fixed the terms melancholia, mania, and dementia. I wish to speak of the effect that is produced upon these conceptions by certain newer ones which, it seems to me, should be welcomed as a great contribution to the understanding of the nature of insanity.

It has always been that some writers have tended to generalize, and to form schemes and classifications that show their goodness by their early death; others tend to specialize and to differentiate many clinical entities, most of which have lived only long enough to be named and then forgotten. There must be some reason for the vitality of that generalization under which Griesinger defined melancholia as including states of mental depression—

[1] This article embodies substantially the remarks made by the writer before the American Medico-Psychological Association, at New York, May 24, 1899. It is a *preliminary communication* of some of the results of special clinical studies that have been made during a number of years at the McLean Hospital, especially in the last four years. The publication of such studies will be continued, as they become sufficiently advanced, by the medical staff.

mania as states of mental exaltation—and dementia as states of mental weakness. This is a dominant conception to-day, in some form or other, as is strikingly shown in Clouston's latest edition of one of the best accepted of modern text-books. In the many attempts to get away from this generalization, the most notable one of modern times embodies the doctrine of heredity as an explaining principle. Under this the conception of paranoia has had its rise, prevalence, and decline to its truer value, within thirty-five years. The "systematized delusion" being held to be its prime characteristic, nearly all forms of insanity were included, and there were many named varieties of paranoia for which a common degenerative tendency was claimed. The term paranoia is accepted now for comparatively few cases of definitely manifested primary delusional insanity; and it is coming to be realized that a neuropathic heredity does not have the relation of an essential cause in the acute psychoses, any of which may occur without such predisposition. But out of these conceptions in regard to heredity, and concerning the form and content of the delusions, have come distinct contributions to our knowledge of mental diseases. We have been reverting to our old standbys—melancholia, mania and dementia, and their varieties—for the classification of the large majority of cases, which we have to tabulate in our hospital statistics.

One of the most interesting contributions that has been made to this subject has been the proposition that the acute psychoses constitute one disease that may be called "ordinary insanity," of which melancholia, mania, and dementia are but stages in the descent towards dementia. In English medical literature the best presentation of this conception was made by Sankey in his lectures first published thirty-three years ago, and in a revised edition in 1884.[1] But, as he says, "this is no new doctrine or discovery." Griesinger agrees to the unity of melancholia and

[1] *Op. cit.*, p. 101. "Cases of mental disease vary much in their course or progress. At one period, the subject will present phenomena totally different from the symptoms presented at a different period. I maintain, however, that the case must be considered to be of one species throughout; such is the rule in general pathology and there are no grounds for having a different system in Insanity, however long the case may last. For a case to be placed under a different name, it should differ from all other cases, as distinctly as acute rheumatism from typhoid fever."

mania as forming degrees of the same morbid state; and other writers in recent years have held this view. Yet the striking diversity in the manifestation of the emotions in the clinical pictures presented by the two phases of depression and exaltation leads to their being still described as two diseases. But while Sankey made some most instructive explanations of the mental changes from melancholia to mania he was evidently misled by his idea of "stages" in the progress of "ordinary insanity" toward dementia: they were 1, melancholia; 2, mania; 3, chronic melancholia and mania, and alternating forms; 4, dementia. The word "chronic" in his third stage refers merely to duration and implies the beginning of dementia; while this may be a stage of progress, it is not a distinct phase or aspect of the clinical picture as the depressive and excited conditions are. The unity of ordinary insanity really includes only these two phases; and there is no fourth stage, for it is comparatively rare that even a slight form of dementia occurs in the true acute psychoses; this will be explained in the course of this discussion.

The latest and most original contribution is that of Kraepelin in his studies and clinical methods which are giving us perhaps the most illuminating conceptions of insanity that we have yet received as explaining principles. For the bringing of these to us in America I wish to give here the credit due to Dr. Hoch, who went from the McLean Hospital to Heidelberg in 1894 to be a student with Kraepelin and again in 1897, and to Dr. Meyer, who also was there in 1896. During the last three years and more, in the discussions in clinical conferences at the McLean and Worcester Hospitals the Kraepelinian propositions have been worked over and, case by case, have been tested to their acceptance, modification or rejection. At the McLean Hospital we have been very conservative; and holding fast to that which seemed good in our observations in the past we have adopted new conceptions only as they have stood trial in their repeated application to concrete cases. It is one of the merits of Kraepelin, and an evidence of the soundness of his teachings, that others as well as himself, in working out the principles he lays down, must advance from one formulation of tentative conclusions to another in progress toward the truth. Nothing could be more stimulating and encouraging in our work. The funda-

mental conception is that in conformity with general pathological principles there must be an underlying pathological process for every distinct form of mental disease manifested by a definite symptom-complex. We recognize this in general paralysis, but here we take into account, as the principles of general pathology require, the cause, the pathology, the symptoms, the course, and the termination of the disease, in order to understand it in its entirety. In like manner, although yet far from demonstrating underlying pathological processes for the acute and other psychoses, we have a right to make the assumption, for each real disease; and we may, therefore, proceed to differentiate the clinical forms upon the basis of this conception, always remembering that we must include what we *can* observe of the cause, symptoms, course and outcome. We may note for example, in one group of cases, recurring attacks of simple depression, with recoveries, and with such absence of terminations in dementia as to permit us to say that these cases do not tend to it; in another group, each individual may have first a depressive attack, afterwards a recurring attack of excitement, and later other attacks, either depressive, excited, or of mixed types, but still no characteristic tendency to pronounced dementia. Again, in another group of cases, there may appear in each from the outset, certain characteristic traits that declare a tendency to dementia; although in some there may be remissions, even equivalent to recoveries, there are, nevertheless, in the symptom-complex the traits peculiar to the underlying dementing process. General paralysis is only a pronounced type of a disease presenting a well-recognized course and outcome, with sometimes superficial manifestations of depression or excitement in its course; and having possible remissions there is a certain progress toward dementia from the beginning. These conceptions bring out and emphasize the principle that when, besides the symptoms of any present attack, we take into account the course of the disease through the patient's life-time together with the final outcome of the disease, we are no longer bound down by the necessity of naming the disease melancholia at one time because there is a depression, and at another time having to call it mania because of excitement. The true criterion is the essential tendency of the disease as a whole to recovery or dementia. I regard this

as the key to the teachings of Kraepelin—this is his illuminating contribution. It follows from these conceptions and his methods of clinical study that in every case we look, from the outset, for the prognosis; we search the symptom-complex for the characteristic differential traits that point to recovery and recurrence, or to dementia with possible remissions. With such a conception of the nature and natural history, so to speak, of any given form of mental disease there is a better understanding of what may be done to promote recovery, and efforts are stimulated to overcome conditions that do not necessarily denote permanent deterioration as they superficially appear to do. It is in such considerations as these that hope of progress lies.

Kraepelin, in the fifth edition of his text-book on psychiatry, still treats the larger groups of the insanities, which we have known as melancholia, mania, etc., as chiefly belonging to the class of "constitutional psychoses" included among the "mental diseases originating from faulty endowment." But in the sixth and last edition, recently published, this ascribed relation to predisposition has disappeared and he purposely avoids schemes of classification. His lectures deal with forms of insanity as quite distinct subjects. But we, who have been grounded and brought up in the teachings of our fathers and have associated together or differentiated the forms of insanity that we most commonly see, cannot drop our working knowledge of our cases; we cannot transport ourselves to a new point of view without great apparent confusion if we lose our bearings. The student, who must still learn his psychiatry largely from our text-books as they are, must have, as well as we, some clue to what becomes of our melancholias and manias, for example, under the newer conceptions which really seem to clarify the confusion of the older teachings. It is all the more necessary, to consider the effect of Kraepelin's teachings upon our nomenclature and customary classification because in his endeavor to relieve the new position from embarrassment he tries in a number of cases to discard an old name and to find a new one to designate a newly differentiated symptom-complex.

Kraepelin (5th edition) conceives the "acute psychoses" as constituting forms of periodic insanity; these are: 1, manic forms (simple mania); 2, circular forms, depressive conditions and ex-

pansive conditions (melancholia and mania); 3, depressive forms (simple melancholia). He has preserved the word "melancholia" in the term "Melancholia" applied to climacteric cases; but finding "Involution Psychosis" a better designation we (at McLean Hospital) have seen no reason for taking the word "melancholia" away from the group of cases characterized by depression. Neither did we see in the cases we have studied any reason for making a separate group of "Manic Forms." There being a quite obvious objection to the term "Circular Forms," we regard these as "Ordinary Insanity—depressed phase and excited phase"; Kraepelin himself (6th edition) dropped the word "circular" and substituted "Manic-Depressive Insanity," which may be adopted usefully at the present stage of this discussion. Our studies, therefore, gave us the following results, comparing the older conception of the "acute psychoses" with the new one:

TABLE I.—ACUTE PSYCHOSES.

MELANCHOLIA. States of Mental Depression.	MELANCHOLIA, Simple. (Periodic forms.)
MANIA. States of Mental Exaltation.	DEPRESSIVE-MANIACAL INSANITY. Depressed Phase (Melancholia). Excited Phase (Mania). (Periodic and circular forms.)
DEMENTIA. States of Mental Weakness.	Forms above named tending to recurrence and recovery.

This table serves to indicate that the "melancholias" of the old order may be divided, part of them remaining as simple melancholia and another part being assigned to the "depressed phase" of the double form; the "manias" in large part also pass into the "excited phase" of the latter form. But, so far, only cases tending to recovery, and not to dementia, have been kept; there remains a part both of the old melancholias and manias that do tend to dementia. Taking away entirely from the "acute psychoses" the cases tending to dementia, this class is cleared of those difficult to assign, and which include the type of cases that may be properly called Katatonia. These katatonic cases tending to dementia thus disposed of, are the ones that often present varying states of depression, excitement, confusion, etc., in

the course of one attack, and by reason of their varying emotional states have always created embarrassment in grouping them among cases with which they have been formerly associated. On the other hand, these cases of katatonia, when grouped with other dementing cases of the well-known types of primary dementia and hebephrenia, are found to possess as characteristics certain traits common to those clinical forms; more will be said of these later in this discussion. The destination of the katatonic cases being thus indicated, it is of great interest to see the effect of their removal from the "acute psychoses." The question comes here as to what is gained by these changes. They are made in recognition of a fundamental principle. The conception of melancholia as states of depression and mania as states of exaltation constituting two diseases, has long dominated psychiatry, misled it as long, and retarded its progress. It is based upon the changes in the emotional nature—the criterion is the state of the *feelings*. In the depressive states there is something left of the normal reactions of the feelings as representing the truth of the somatic conditions, but in the exalted states the sense of well-being is fictitious and out of relation with somatic facts, and no index of underlying conditions. However this may be, instead of discriminating the "acute psychoses" upon the basis of so fluctuating a criterion as the feelings, Kraepelin points to the course and outcome of the disease as the determining facts—the criterion is as to whether or not there is a *tendency to dementia*. The "acute psychoses," the forms that are with most reason termed "symptomatic" and "functional" do not tend characteristically to dementia; recurring attacks throughout a life-time do not produce it, except sometimes, perhaps, in the slighter degrees in the later years of life, or after many attacks.

One other consideration remains to be mentioned here in connection with the "acute psychoses"; it is with regard to the place of what we have known as "confusional insanity." Kraepelin (5th edition) describes certain forms of mental disorder which he calls "exhaustion psychoses" as conditions that may be rapidly produced by any strongly exhausting influences, including the effects of mental shock or stress. These appear to me to belong among the cases of confusional insanity, as being in the nature of *deliria* in relation to conditions of acute exhaustion. They always

tend to recovery, and should, therefore, be classed with the "acute psychoses."

The conception of pathological processes as underlying "mental diseases," as far as we are yet warranted in differentiating the symptom-complex of each clinical form, gives us the criterion of the tendency to dementia as a basis for a simple and logical classification. Making such use of Kraepelin's designations as has been explained, and introducing "confusional insanity" in its appropriate place, the following tentative classification results. It comprehends the idiopathic forms of insanity in as broad and simple a generalization as that of Griesinger's formula, but upon a fundamentally different basis:

TABLE II.—CLASSIFICATION OF INSANITY.

ACUTE PSYCHOSES. (Not tending to Dementia.)	MELANCHOLIA—Simple ("Periodic").	
	DEPRESSIVE—MANIACAL INSANITY ("Periodic," "Circular"). Depressed Phase (Melancholia). Excited Phase (Mania).	
	CONFUSIONAL INSANITY (Exhaustion Psychoses).	
ESSENTIAL DEMENTIAS, OR DEMENTING PSYCHOSES. (Tending to dementia.)	DEMENTIA PRÆCOX.	Primary Dementia. Hebephrenia. Katatonia.
	GENERAL PARALYSIS.	
	SENILE DEMENTIA.	
CHRONIC PSYCHOSES. (Not tending to grave dementia.)	INVOLUTION PSYCHOSIS.	
	PRIMARY DELUSIONAL INSANITY (Paranoia).	

It is impossible, for want of time, to discuss here the differentiation of the symptom-groups which constitute these forms of insanity. Each one would show distinctive characteristics which have been verified many times in series of well-studied cases. It should be explained, however, that "dementia præcox" is Kraepelin's latest designation for the three types which it includes. Certain characteristic traits common to these three are revealed by intimately studying the workings of the mental elements and their variations. These characteristics being recognized, it is found

that a fundamental unity exists even between clinical pictures so diverse as that of a primary dementia, apathetic and chronic from the beginning, and that of an actively developed katatonia running through a mixed manifestation of symptoms resembling those of the acute psychoses in sometimes a long and apparently hopeless illness, but yet yielding at last a remission apparently equivalent to a recovery from that attack. While it becomes necessary, and is very helpful in classification, to make a diagnosis of "dementia præcox" in quite a number of cases of which it can hardly be said that they are distinctly of the type either of primary dementia, or hebephrenia, or katatonia, still their relationship is very obvious. The character of general paralysis and senile dementia as manifestations of surely degenerating disease-processes, gives them a kinship with the usually more slowly progressive dementias. Involution psychosis (climacteric) and paranoia are forms that tend to run long courses, chronic from the beginning; and not tending to grave dementia they may, for the present, be called the "Chronic Psychoses." With regard to these Kraepelin would place together "Melancholia" and Senile Dementia as "Devolution Psychoses," but the present tentative grouping does not conflict with that suggestive idea.

The progress that has been made through the clinical studies which have yielded the results so far presented here may now be traced another step. I have already indicated that in studying Kraepelin's proposition (5th edition) to separate the "manic forms" and "depressive forms" as distinct from his "circular forms," it was found, at McLean Hospital, that the history of the cases did not warrant such separation for the "manic forms." Kraepelin (6th edition) now not only omits these, but he leaves out, as not sufficiently differentiated, the simple "depressive forms" also, which we have retained as a convenient division; he retains, therefore, for what we have called so far the "acute psychoses," only those under the designation "Manic-Depressive Insanity" with its two phases. While there is reason, in my opinion, for contending that the depressive state comes first, in respect to the degree of the disorder, and in the evolution of the disease, thus making preferable the term "Depressive-Maniacal Insanity," we should probably agree with Kraepelin in this his latest view, excepting a question as to a different designation of this

double form. This is a most interesting conclusion, for we have only to prefer the phrase "Ordinary Insanity," unsatisfactory as it is, to his of "Manic-Depressive Insanity," and we are brought around again to a more familiar terminology, viz.: "Ordinary Insanity," including two phases; 1, depressed phase, melancholia, and 2, excited phase, mania. This leaves us the easily-used characterizations of the differences in the contrasting emotional states, which still indicate sufficiently the accompanying symptom-complex in each phase respectively.

Again, the question arises "What have we gained?" The gain is one of immense importance; it is a radical change of the point of view. We see now that melancholia and mania are but phases manifesting different "degrees of the same morbid state"; we see that these together are the expressions of a probable pathological process which has its course sometimes extending throughout the life-time of the patient, and that it always tends to a termination in recovery with sufficient certainty to make it characteristic. At the new point of view we adopt the criterion of dementia as the distinguishing mark of the differences of course and outcome. Then, for the next group of cases, assuming the phrase "Dementing Psychoses" to be allowable, we place first in this group the cases we have long known as tending to dementia, under the various names of primary dementia, hebephrenia, adolescent insanity, etc. We find that with them belong the cases that have always been inharmonious with the group of "acute psychoses," and which we have had to designate by special descriptive terms as varieties of melancholia or mania. The contributions of Kahlbaum and Kraepelin to the study of katatonia here find their place. The term "Dementia Præcox," thus bringing together with katatonia a number of these variable forms that represent dementing processes, unifies them as belonging to one group, through the elucidation we have gained of certain characteristic traits common to all. Not only this, but, as already mentioned, it is also significant of the value of the generalization that there are cases which, because of these traits, find here a fitting place when they could hardly be designated by any one of the special names. This is true of cases that change from one appearance to another in the unessential variations of the symptom-complex in the same or in different attacks. A gain

is obvious, also, in finding in this group a logical place for its two other members—general paralysis and senile dementia.

The foregoing table, with these explanations, represents our working formula of classification, at McLean Hospital, in studying the clinical forms of mental disease and their relations to each other. We have to say, however, with respect to the group of "Chronic Psychoses," which term is ours and not Kraepelin's, that we are not yet quite satisfied as to their relations to the other groups. In other words, "involution psychosis," (Kraepelin's "melancholia"), and primary delusional insanity are yet open to question in this regard, although the former has proved to be one of the most interesting of these studies. Still, there are several plain indications in regard to these two forms of insanity, last named. To designate in this connection a group of cases as "chronic" introduces an inconsistent criterion; as they tend to dementia to a certain degree, they belong in the general class of dementing psychoses. Of these there are two special forms, or, perhaps, degrees of one form, which Kraepelin would designate as related to the process of "devolution." On the ground that the process of involution, beginning with the climacteric of middle life and terminating in senility, is a natural process of physiological decline, we may argue that psychoses occurring during that period should present some characteristic variations from the phenomena of the same underlying disease process in earlier life. At all events, the relation of climacteric insanity (involution psychosis) to senile insanity as types, or degrees, of a dementing process, is sufficiently certain; and they have a certain kinship as "Devolution Psychoses."

For like reasons to those above stated the objections to the word "chronic" apply to the use of the word "acute" in the term "acute psychoses" customarily applied to the so-called "symptomatic" and "functional" forms. The dementing psychoses are often "acute" in respect to the character and duration of the attacks. The term "Recovering Psychoses" might be used in contrast with the "Dementing" forms; but conservatively adhering by preference to the familiar designation "Symptomatic and Functional Psychoses," we may leave it for future determination whether they represent simply curable "conditions," or "underlying disease-processes."

"Progress in the clinical study of psychiatry," guided by the foregoing considerations, may be said to have brought us as "alienists of the old school" to a new point of view. In this position the effect of the new views should be made intelligible to us, as far as a scheme of classification can indicate explaining principles, by the foregoing table; this will be aided, perhaps, by some slight modifications of terminology and arrangement. The one now proposed, with its harmonizing interpretations of the nomenclature, includes substantially the conceptions of Kraepelin. While it points to the new problems in the discrimination of the clinical forms of mental disease, it does not disconcert us with changes of familiar names, although some of these must stand for more specific meanings. The following table is proposed as fairly indicating the net results, in regard to classification, of the special studies under discussion:

TABLE III.—CLASSIFICATION OF INSANITY.

"Symptomatic and Functional Psychoses" (Not tending to dementia).	Ordinary Insanity (Depressive—Maniacal). Depressed phase—Melancholia. Excited phase—Mania.	
	Confusional Insanity (Exhaustion Psychoses).	
Essential Dementias, or Dementing Psychoses (Tending to Dementia.)	Dementia Præcox	Primary Dementia. Hebephrenia. Katatonia.
	General Paralysis.	
	Primary Delusional Insanity (Paranoia).	
	Devolution Psychoses.	Involution Psychosis. Senile Dementia.

This table includes only the idiopathic forms of insanity, leaving for classification in the usual way those from neuroses, organic brain disease, mental defect, and the toxic forms. The conception of the idiopathic psychoses and their relations to each other as embodied in this table affords us a helpful working formula to keep before us the underlying guiding principles. It may be said that there is danger in such a formula from its tempting us as students of psychiatry to force our observations of clin-

ical manifestations to fit a preconceived programme. This, surely, would be a misleading use of a scheme of classification; at the best, any such scheme should be treated as an attempt to hold up to view the fact that there are in this matter certain fundamental principles, which being applied in certain ways serve to reduce to some degree of intelligible order an array of "clinical entities," that would otherwise remain in forbidding confusion. We even have to find out these principles by testing them in these ways. Classifications fail by attempting too much; the old formula, based upon the feelings, has held because it does not go beyond certain simple, observable facts, although its inadequacy is manifest. The present suggestion has the merit of simplicity; we are are led to it as the immediate effect of the application of one fundamental principle. If this is a true one, it must lead us further in the progress that has been so long hindered by erroneous conceptions.

In pursuing the studies under the methods employed in the clinical work at the McLean Hospital it has been the endeavor to reach well-grounded conclusions. Those incorporated in the tabular statement of results, as far as they can be shown by the condensed expression required in a form of "classification," must continue to be subjects for study. It may prove that the conceptions and conclusions do not necessarily conflict, as they are held to do, with some of those long held by careful observers and students of psychiatry; and truth may, perhaps, be learned by studying these apparently conflicting views in an attempt to harmonize them. When it was my privilege to present to the Association, at its meeting in Newport, in 1888, a discussion of this subject,[1] the proposition was offered that the acute psychoses comprised "Ordinary Insanity" in three stages, melancholia, mania and dementia. It was argued that on the dual basis of nervous exhaustion, or its equivalent, and toxicity there could be traced a regular evolution of the symptom-complex of each succeeding stage from the mental symptoms of normal and pathological fatigue. These propositions are not far astray from those

[1] See articles on "The Mechanism of Insanity," in the AM. JOUR. OF INSANITY, Vols. 46, 47, 48, for a part of that discussion; also "The Shattuck Lecture, 1891," on "The Mental Symptoms of Neurasthenia," *Bost. Med. and Surg. Jour.*, Vol. 125, p. 49.

that have been quite commonly accepted in recent years. It is fair to say that this is held to be quite inconsistent with the conception of disease-processes as advocated by Kraepelin: given a disease-process it must have its own symptom-complex as a mental disease; one disease does not run into another, and "manic-depressive," or "ordinary insanity," as one pleases, has nothing to do with neurasthenia, for example.

There is some satisfaction in noting the support that has been gained for the unity of melancholia and mania as simple phases or degrees of one morbid process; and it seems reasonable to remove the cases tending to dementia from the group called "acute psychoses." All will agree that neurasthenic conditions, more or less acute, are common antecedents of these psychoses. The problem is an open one as to whether they occur independently of "exhausting" antecedents; or whether these existing, and creating a predisposing condition, the true disease-process then begins; or whether the symptom-complex must be made up of fundamentally different elements for each form of the psychoses. Again, are there certain "fatigue-symptoms" that may exist alone in conditions of simple exhaustion, but which must be taken into account as possibly appearing in all the psychoses, sometimes as an attending effect of the onset of disease, just as general paralysis sometimes has its first manifestation in an apparently neurasthenic depression, or an excitement? These are interesting studies; and there is the suggestion that the "acute psychoses," as now limited and always tending to recovery, may, in all forms, bear the relation of *deliria* to somatic conditions. An important step in progress is made when we become able to recognize definite problems such as are presented by these studies. The "fatigue question," on the one hand, touches directly the problems of nutrition and of the treatment of conditions indicated by changes in the mental symptoms; the disease-process question, on the other hand, draws attention to the study of structural changes and the possible correlation with them of the mental phenomena.

There seem to be reasons for hoping that such clinical studies are bringing substantial advancement to psychiatry; the interest excited by these methods of study, and the sense they give of an opening way for progress in which many attractive problems are appearing, bring great encouragement and stimulation to further efforts in pursuing clinical work.

CLINICAL CASES.

IV.

PSEUDO-DEMENTIA PARALYTICA URÆMICA.

By HENRY J. BERKLEY, M. D.

The following case is interesting from both its psychiatrical and neurological aspects, and well illustrates the difficulties of an etiological diagnosis in progressive paralysis of the insane. When admitted to the asylum the man exhibited a perfect clinical picture of the maniacal form of that disease, in addition to a partial left hemiplegia. The degree of this unilateral loss of motor-function indicated a gross lesion of the right hemisphere, but this was not found at the autopsy, and only an obliteration of the posterior communicating artery could be discovered to account for the paralysis—a somewhat doubtful theory.

In the microscopic examination, the universal degeneration of the medullated cortical and sub-cortical fibers, together with some scattered foci of necrosis around greatly diseased blood-vessels—a frequent find in the presenile dementias, and often accompanied by a moderate train of paralytic symptoms—might be considered a sufficient reason for the presence of the hemiplegia, had not the same lesions been distributed over both hemispheres, and had the paralysis been a comparatively recent one. The scattered islets of sclerosis in the left pyramidal tract below the decussation of the pyramids, together with their absence on the right side, showed conclusively, however, that the right half of the brain was more seriously implicated in the vascular-necrotic lesions than the other half, but lends no aid as to an estimate of the duration of the damage. Unfortunately an examination of the lower portions of the cord was not permitted, and we could not ascertain the condition of the posterior tracts.

The loss of the knee-jerks is interesting, showing that a second disease process had stepped in and ablated the most characteristic indication of the first—the exaltation of the reflexes.

The microscopic examination showed all the most characteristic features of the lesions of paretic dementia; vascular disease of the periarterial kind, disappearance of the medullary fibers of cortex and ganglion, and secondary alterations of the nerves and neuroglia cells of a degenerative atrophic order.

The history of the patient was an unusually clear one, an older sister having carefully watched him from childhood, being cognizant of all his dissipations and excesses, but knowing that he had had none of the secondary signs of syphilis, and that he had never been treated for that disease. The alcoholic history was distinct, and in all likelihood from the abuse of spirits arose the combined arterial-renal lesions, complicated, finally, by disease of the proper brain tissues.

This, in unison with Case I, tends to prove that the pathological lesions of paresis may be induced by other causes than the syphilitic virus, and that the toxins and toxalbumins engendered in chronic nephritis, may induce a symptom-complex, indistinguishable clinically, except by the presence of the renal lesion, from the true form.

J. W. K., æt. 41 years, saloonkeeper, was admitted to the City Asylum, March 12, 1898.

The family history detailed that the father was killed in an accident, and the mother died at an advanced age. There was no ascertainable predisposition to insanity. There is a sister who is mentally well-endowed.

The past history of the patient showed only a single serious illness, variola, at the age of twenty-one years. He was considered to be a bright boy, but was very difficult to control and would not go to school with any constancy. He, however, learned to read, write and cipher before he eventually left school at the age of thirteen years. The following seven years he worked steadily at a foundry. He then became dissipated, drank heavily, and became a saloonkeeper; which occupation he held for eight or nine years. There is a doubtful history of syphilitic infection many years ago, which does not seem to have been followed by secondary manifestations. Five years before his admission to the asylum, while gambling and drinking, he had an apoplectic stroke, with subsequent paralysis of the entire left half of the body. At first the paralysis was complete, except for slight voluntary movements of fingers and toes, together with some reten-

tion of the power of flexion of the left hand, but within the short space of two weeks he was able to walk with the aid of a stick. Considerable permanent weakness of the leg and arm, however, continued, and was persistent until the beginning of the present trouble, the left leg always being dragged with a circular motion.

On March 4th of this year (1898) without any previous warning and while walking on the street, he was seized by an apoplectiform attack and fell upon the sidewalk. He was picked up, carried into a neighboring house, and his sister was sent for. On her arrival she found him lying on a lounge, breathing quietly, conscious, and replying coherently to questions. He told her he could not go home, as he was paralyzed again, and complained of tenderness and pain on the left side.

After he was carried to his home it was immediately noticed that his mental balance was disturbed. He several times attempted to get out of bed and fell upon the floor. He could not be induced to reply directly to questions, but rambled on in an incoherent manner. He did, however, recognize friends, but could not recall their names. Sleep was poor. It is stated by his sister that previous to the present attack there had been no signs of mental derangement. On March 8th he became suspicious, more voluble, and refused to take food.

On his admission to the institution he was much excited, very loquacious, had numerous rapidly changing delusions, chiefly of an ambitious character, believing himself to be worth millions, that he was an expert workman, and was going to shoot all the "niggers" with cannon filled with diamonds so that their bodies would be worth more after death, with the jewels in them, than when alive.

On the day after admission he was extremely active about the ward, talking to all the patients, impressing his greatness upon them, and moving around constantly, and except for a slight dragging motion of the left foot showed no evidence of having been paralyzed.

The delusions were as vivid as on the day previous, "shooting niggers" seeming to have especial attractions for him. When asked if he would not be hung for murdering so many men, he replied that no one could kill him as he had had his heart taken out and kept it hanging upon the chimney piece at home. Be-

sides numerous other delusions of a grandiose order he had some hallucinations of an alcoholic nature, seeing rats, monkeys, snakes, men, in rapid procession, but these sense deceptions were evanescent, and were soon replaced permanently by the grandiose delusions which changed daily, one being hardly less extravagant than another. Among the most prominent of the delusions was one that he had millions of barrels of whisky stored in the side-rooms of the ward, and he spent much of his time in vain struggles to find it.

When ordered to follow the ordinary routine of the institution, going to dinner for example, he became intensely excited and refractory. All idea of decency was lost, the man would strip himself before the fellow-patients, or utter the most obscene and revolting language. His habits were also uncleanly, and he was destructive to his clothing. The vegetative functions were normal; appetite excellent. The nights were spent in restless wandering about his room, and in constant vociferation.

The urinary examination made the morning after admission showed the excretion to contain a small quantity of albumin, with urea 37 grm. per liter, and uric acid also in excess. The chlorides, sulphates and phosphates were normal. There was no reaction on the application of the tests for bile, indican, or sugar. Microscopically, numerous hyaline and granular casts, mucus cylindroids, pus corpuscles, and red-blood cells (from eroded urethra), and uric acid crystals were found. The urine had a specific gravity of 1026.

The physical examination showed a flabby, though stout, individual of 175 lbs. weight, with dolichocephalic head and very prominently elevated frontal suture. The motor functions of the eye muscles were normal; those of the mimetic facial muscles showed a pronounced tremor. The gross strength was not markedly diminished, and there was little difference in the hand grasp between the right and left side. The handwriting shows serration of both upward and downward strokes. Locomotion, except when the patient is much excited, is hardly possible to any extent, without assistance. He drags the left foot with a circular motion. There is a degree of ataxia of the movements of the right lower limb that is not present in the upper member.

The wrist-jerks, elbow, and other deep reflexes of the upper

extremities are greatly exaggerated. In the lower limbs the knee- and ankle-jerks are absolutely lost. The skin reflexes vary according to the location, whether upper or lower limbs. The pupillary reflexes are retarded, and the left eye reacts to light and accommodation more slowly than the right. The pupils are in a state of mid-dilatation.

The special senses seem to be normal to such rough tests as could be made. Pain sense is not dulled, and common sensation is not markedly impaired. Articulation is extremely defective, so much so that it is difficult to understand the patient. The disturbance of phonation is of an ataxic order.

The tremor in the mimetic muscles is greatly increased when the patient becomes excited; then the increased stuttering renders articulation entirely incomprehensible.

The further physical examination showed the several arteries of the arms and temples to be diffusely sclerotic, and a recent running sore at the urethral orifice, from which there was a constant discharge (probably caused by masturbation, though denied).

During the week following his admission there was no marked change in the mental or physical condition, the delusions being of the same general character as those already mentioned, though varying from day to day.

In the second week it was noticed that the patient was becoming very sleepy. Urinary examination demonstrated an increase in the amount of albumin, but otherwise no change in the chemical constituents of the fluid, which has always been abundant. On March 25th, he became semi-comatose, and had to be taken from his chair to the bed. He then rapidly became very feeble, remained in a half-sleepy state, from which he could be aroused for a moment, and would reply incoherently to a question, and then relapse into the semi-comatose condition. The temperature now steadily rose to 104°. The abdomen became tympanitic, palpation showing no fluid. The coma gradually deepened, and all control of the sphincters was lost. The patient continued to pass a full average amount of urine until the end. Dissolution took place on the early morning of March 30th, after lowering of the circulation, with rapid formation of bed-sores over the back and sacral regions, and cyanosis of the extremities.

Autopsy, four hours after death, the body being still quite warm, and rigor mortis incomplete. There was bluish discoloration of the dependent parts of the body. Pupils evenly dilated. No emaciation. No examination of other viscera than the brain was permitted.

The skull bones presented nothing noticeable. The brain with its appendages weighed 1240 grammes. The arteries at the base, and in the Sylvian fissures had scattered patches of atheroma showing through their outer coats. The basilar artery also had a small aneurism. The right posterior communicating artery of the circle of Willis was completely obliterated at the junction of a lateral branch, probably by an old thrombosis, and the posterior half of the artery had dwindled to a cord. The larger pial veins were congested and tortuous. The pia over the frontal and mid-regions of the brain was greatly thickened, gelatinous, turbid, with whitish lines marking the lymph spaces by the side of the larger and smaller vessels. Over the posterior half of the brain, this condition though still present, was far less marked than in the anterior regions.

The convolutions over the anterior lobe looked, in comparison with those of the posterior portions, small and atrophied, but there was nowhere any local disease visible in the cortex. The lateral and third ventricles were greatly distended with clear fluid, the choroid plexuses were granular, but the ependyma was not greatly thickened. The fourth ventricle was not distended with serous contents. The right pyramidal tract in the medulla showed some differences in color from the left but was not atrophic. No focal lesion could be found in the upper territory of the right pyramidal tract, nor was there coarse lesion of the brain substance to be discovered elsewhere.

Microscopical Examination.

Portions of the cortex from both sides of the anterior and posterior sensory-motor regions, from the paracentral lobules, the central ganglia, the medulla oblongata, and upper cervical regions were fixed in ninety-five per cent. alcohol and in Muller's fluid, and after a suitable interval for hardening, were variously stained with Weigert hæmatoxylin, Nissl methylene-blue, hæma-

toxylin, safranin, eosin, picric acid, fuchsin and nigrosin, also by the rapid silver method.

Practically there was little difference in the results of the examination of the cortex, except with the Weigert stain, which showed a decrease in the number of medullated fibers on the right side, over those on the left. In both hemispheres the numbers of fibers were far below the normal, though the staining of the sections was all that could be desired, and here and there local patches, containing finer medullated tubes than elsewhere, were fully stained, marking the degenerative process as a local one dependent on a varying degree of vascular disease.

The radial fibers in all the sections of the cortex, from both anterior and middle regions, are very sparse and varicose. The intercellular network shows a great diminution of the tubes, and an unusual varicosity of those remaining. The outer tangential band, while in places well stained, exhibits everywhere very few nerve fibers, and these varicose. The inner boundary of the band is perfectly defined. The same condition of extreme varicosity, coupled with considerable diminution of the numbers of the medullated fibers, applies to the central ganglia, though here the diminution is much less remarkable than in the radial fibers of the cortex.

Meninges.—These membranes show but little actual thickening, and that dependent upon a rather irregular distribution and infiltration of the parts adjacent to the vessels with round cells each having a small amount of protoplasm and a large nucleus. The meningeal arteries and veins show a widely distributed but not very florid periarteritis. The inner layers are not involved to any decided extent. No vessels could be found showing obliteration either from periarterial changes, or, in the case of the larger ones, from endarterial ones.

Cortex.—Within the gray layers, the periarteritis is distinctly of the nodular type, and more decided than in the meninges, though still unequally distributed in the sections from the several regions, being more intense in the territory of distribution of the Sylvian artery than elsewhere. The occipital lobe has suffered considerably less than any other region of the brain. The process is just beginning at a single point at one side of the vessel, around a considerable proportion of the arteries affected.

Around the sheaths of others, the aggregations of the round cells is very considerable, the outer lymph space being filled by them, the inner one obliterated by pressure from the dense new growth. When the process has advanced to a considerable extent, there is a decided tendency for the outer layer to split away from the more internal ones. Only in places where the agglomeration of the nuclei is very great is there a diseased condition of the muscularis and more intimate layers, and even here the disease is minimal. All the perivascular spaces are much widened, and between the nuclei therein contained are accumulations of hæmatoidin debris, and in some instances a few crystals. The spaces are free from any quantity of extravasated leucocytes, and have no masses of hyaline exudate. The media of the vessels also seems to be free from hyaline changes.

Around a few vessels where the nuclear accumulation has been more considerable than in others, there is a beginning involution and destruction of these cells, but on the whole this condition is rare. Around a few of the more highly-diseased arteries the round-cell growth has overflowed the limits of the perivascular space into the surrounding nervous territory, and penetrated into the tissue along the margin of the vessel. This condition is by no means as well marked as in Case II, though in the several regions affected the alteration is sufficient to disturb materially the nutrition of the fixed cell bodies of the neighborhood.

In the frontal and motor regions, four small necrotic areas around partly obliterated arteries were found extending some distance into the tissue around the vessel, and within this territory changes in the nerve-cell protoplasm and nuclei, as well as in the thick-bodied neuroglia cells and nerve tubes, are to be distinctly determined. The neuroglia of the vascular type is definitely implicated in the retrogressive alterations. The short branched cells have their bodies tumefied, the tentacles swollen, and are differentiated from the other elements of the tissue by differences in staining reactions, particularly to safranin. In the necrotic tissue along the vessels' margins noted above, they have undergone the same retrogressive alterations as the other elements. No idea of the condition of the long-rayed cells can be obtained with the aniline stains. With sections impregnated by the silver method, these long-rayed cells were found to be unal-

tered so far as external appearances go, while the large vascular cells have their bodies considerably swollen, the vascular foot being particularly noticeable for its altered size.

Cells.—The staining with the Nissl method is rather unsatisfactory, as the cells show no very decided evidences of degeneration. In a considerable proportion of the larger nerve elements the granula are preserved in their integrity, while in a much smaller one the protoplasm shows an uniform blue coloration, with no distinction between the chromatic and achromatic substances. With the other aniline colors the protoplasm is irregularly stained. Hæmatoxylin and eosin-tinged sections show nothing abnormal in the condition of the protoplasm. The silver method shows the ultimate dendrites to be few in number, and stumpy, with considerable diminution of the gemmulæ, even where the bodies of the cells show no ascertainable alteration of the contours of the protoplasm. With the safranin dye, the nucleus, nuclear membrane, and contents appear to be normal; with hæmatoxylin the nucleolus is very faintly or not at all colored in the majority of the larger cells, and the caryoplasm is tinged an uniform blue. With eosin-hæmatoxylin the nucleolus appears rose-tinted, in strong contrast with the blue staining of the membrane of the nucleus and of the protoplasmic substance of the cell, showing absorption of acid and rejection of basic stains, the opposite of the normal. The cells occasionally hold two nuclei, vesicular, sharply defined, and presenting no difference from other neighboring nuclei, in contents or contours. The lymph-spaces surrounding the nerve cells of the larger type are moderately large, but hold few lymphoid corpuscles or other contents.

In the necrotic areas, and in some other places along the margins of the vessels, whose sheaths have undergone extensive disease, the nerve cells are hyaline, unstainable by the aniline dyes, and in common with the neuroglia, are undergoing dissolution. These areas are, though, very small, and were probably of little moment in the general process of mental retrogression, simply marking a higher degree of vascular disease.

Central Ganglia.—The vascular state and cell conditions were entirely similar to those of the cortex.

Cervical Spinal Cord, and Medulla.—There is a beginning periarteritis nodosa discoverable everywhere in this region, but no

occluded vessels, or very extensively diseased ones were found. The neuroglia and epithelial cells of the canal were entirely normal. With the Nissl method the granula were everywhere distinct, without a sign of central or peripheral chromatolysis. A few nuclei are displaced from the center of the cell to the periphery, but the occurrence is not frequent. The left pyramidal tract below the decussation of the pyramids contains a few isolated patches of sclerosis in which the majority of the nerve fibers have disappeared.

American Medico-Psychological Association

PROCEEDINGS OF THE FIFTY-FIFTH ANNUAL MEETING.

TUESDAY, MAY 23, 1899.

FIRST SESSION.

The Association convened at 10 o'clock A. M. in the Myrtle Room of the Waldorf-Astoria, New York, and was called to order by the President, Dr. Henry M. Hurd, of Baltimore, Maryland. The Right Rev. Henry C. Potter, of New York, was introduced to the Association by Dr. P. M. Wise, Chairman of the Committee of Arrangements, and addressed the Association as follows:

I count it a great privilege to come here and recognize for myself, and recognize that you recognize the great responsibility of the work with which you are concerned. I was tempted to write and congratulate Dr. Wise when he was kind enough to send me the order for this occasion, when I observed that on it, in brackets, after the title of this Association, was the older title. In other words, that the American Medico-Psychological Association was the late Association of Superintendents of American Institutions for the Insane. I should not have been surprised if you attempted to preserve that title, for it carries with it, I believe, the distinction of being the oldest association of the kind in this country. But in changing it you have dismissed out of it what may be called the caste element. In other words, you have recognized the fact that a great many other people besides the physicians who are in charge of institutions for the insane have an interest and might properly have a place in the work you have to do. So long as you were an Association of the Superintendents of the Institutions for the Insane, you naturally excluded everybody but yourselves. But you, yourselves, I know will admit that there is a large, wide range of co-operation possible so soon as you use a title that will admit to your Association the class that may be described as laymen or laywomen. There is no subject concerning which all classes and sorts of men could have a larger and deeper interest, or ought to have it, than the observation, study and deductions with which you are concerned. One of these days we shall

find somebody who will write a great work on the relations of the mind to the body, and who will treat the whole subject of insanity in those wider aspects of it with which thoughful men have been tempted to deal. And who is there of us who is not concerned with the principal questions which it is your business to be concerned with? Who is there, for instance, who, on the social aspect of it, on the domestic aspect of it, on the criminal aspect of it, is not profoundly interested and ought not to be profoundly concerned in those objects which you have come here this morning to consider? I have often thought, myself, that the relation of the insane to the intelligent might easily be made a helpful relation. One of the most pungent and helpful lessons I ever received in my life I received when a young man, when, one Sunday afternoon, I tried to preach. In the front row of the chapel sat an elderly lady, whom I was afterwards informed was the widow of an eminent Presbyterian divine. She listened to me for some time with a look of disdain, and then stood up in her place and said: "I can't make anything out of that young man," and walked out of the room. I accepted the chastisement and endeavored to be more clear in my exposition of the subject. Even a clergyman's wife is a judge of preaching. A friend of mine in Chicago, who is very excellent and devout, and I am bound to say very dull, was asked to go to the insane asylum to preach one afternoon. When he got there the superintendent asked him what he intended to preach about. He said: "Oh, I have written a sermon on the value of the Gospel to the insane." The superintendent said: "Well, you must not preach on that subject here. These people do not believe that they are any more insane than you are." He said he could preach only upon that subject, which he had notes upon. "Isn't there anything else you have in your bag?" He said: "Oh, yes; there is here a sermon I preached to my congregation this morning on Foreign Missions." From the title the superintendent concluded that this would be a more appropriate discourse for the occasion. During the sermon my friend was so much impressed with the attention of one of the gentlemen present that, after the sermon, he said to him: "You appeared to be interested in the subject of my sermon." "I was." "And what interested you the most, may I ask?" "Well, sir, after you described the picture of pagan life in the East, the Hindoo mothers coming down to the banks of the Ganges and casting their babies under the wheels of the car of Juggernaut, I kept wondering why your mother, when you were a baby, didn't throw you under the wheels of the car of Juggernaut." (Laughter.) A lesson which I have no doubt he needed.

It stirs one's mind to think of the subtle relation of those whom we often describe as insane to those of us who believe ourselves not to be so, although about that subject I believe there is a great deal of confusion. But certainly the relations between the class in which you are concerned and the rest of us is much more important than we are wont to recognize. In connection with the home and married life, in connection with the maintenance of domestic order, and in connection with the conditions

of social life in our American communities, and through all these with the building of the State and the nation, the inter-relations of these two parts of the community I think are far more intimate than those of us who are not intimately concerned with questions such as this are wont to recognize. I am told that in New England the insanity among farmers' wives could be ascribed to the isolation of their lives. There the condition of our life is seen to have a very intimate relation with the conditions under which our communal life exists. And then, still further, as I may rightly remind myself and you, in perturbations or disturbances of what may be called the balance of life, in connection with questions which are to most of us the most profound questions, questions of conduct and religion, there is certainly a question that all men should have a deep interest in. It has been observed that people have often found their way out of the healthy condition under the strain of religion. Sometimes those in charge of our spiritual affairs, I am bound to confess, wander out of their wholesome mental condition under the influence of great religious excitement. Of late years a more healthful religious feeling has been taking root, and, thank God, the exercise of the mind in religion, the exercise of the mind, which is God-given as faith is God-given, has given rise to a higher order of things, for which you will, I know, rejoice as I do. And, furthermore, there is a deeper sympathy with the insane. A friend who has been concerned herself in the service of that unhappy class, mentioned to me a few minutes ago an incident which I shall venture here to recite in her presence, because it seems so pathetic and such an excellent example of what I have in mind. A woman in the asylum on Blackwell's Island being visited during the hot days, was asked whether she did not suffer from heat. She said, "yes." The visitor told her to remember that she was thinking about her. Afterwards she was asked how she stood another heated term. She said: "Oh! I didn't mind it; I knew that you were thinking of me and I didn't mind it." Remember, friends, we can awaken such a sympathy and put it to practical use in the relief of these conditions.

For myself, I have felt in profound sympathy with you because of your isolation. Nothing is more tragic than the way in which we leave the insane alone, and, next to them, leave the men who treat them alone. How little we hear of your great work and how much you are shut up in the institutions in which you work, in the affectionate interest of those you treat. Permit me, as one of the least, to say that we carry you in our hearts and prayers, that we recognize in your work a high and chivalric ministry, and we pray God that His divine guidance may be vouchsafed you. With all my heart as a citizen of New York I welcome you to this place and to this occasion. (Applause.)

Dr. Wise then introduced Dr. E. G. Janeway, who welcomed the Association on behalf of the medical profession of New York City in the following language:

The gentleman who asked me to make a brief address of welcome on behalf of the medical profession, told me I would be preceded by the most eminent gentleman in New York and would be limited in time. Consequently I wrote off the words I should say, knowing the most of the welcome would be extended by my predecessor.

I account it an honor that I should have been requested to welcome you on behalf of the medical profession of New York City on the occasion of your holding your deliberations in the most populous city and the one which, consequently, may derive the greatest advantage from your knowledge and wisdom. This city has, therefore, great interest in your deliberations. We appreciate the fact that this coming together is not so much now for study, but rather for the attrition of the materials of study gathered here and there, and no doubt developed into theories, some of which may be more or less opposed, though possibly attained under more or less similar conditions. In medical associations particularly (Mr. Depew will speak for those of railroad presidents, lawyers, etc.), much of the good comes by learning *viva voce* of such opposed results, and of the arguments by which they can be sustained; not infrequently a flood of light may be thrown upon a knotty problem by judicious criticism by some one who has made investigations along the same line. But you are not here alone for the presentation of views, for the formation or promulgation of theories, for the disputation with those who differ, nor only for the acquisition of knowledge by imbibition. You come to know one another by observation, interested as you are in the same field of study, to use a somewhat inelegant phrase, to size one another up. There is much about a man that can be learned by contact that can never be evolved from the printed manuscript. Personal observation has great value even when, as in the instance of your Association, you are concerned with the workings of the mind, for which as yet there exists no electric ray capable of disclosing passing thoughts nor the impress they leave behind upon the delicate structure of the brain. There is no doubt that in the busy rush of our city, in the excited state of the active business mind, in the speculator's mentality, in the mind even of the quiet student surrounded by those who are so energetically active, much might be gleaned of interest to those making psychological studies. Your deliberations and your considerations are much more undoubtedly with the view of apprehending the *rationale* of the alterations whose oncoming indicates the mind diseased, and the means and measures which shall be able to avert the ever-increasing tendency towards mental instability. The medical profession of this city, as its citizens, have a deep interest in this matter, for we recognize that there exist here many causes which tend toward the development of mental instability which may affect the individual or wait until the succeeding generation to leave its sad effects upon descendants. Should you only propose theories of useful import these can be gathered up into efficient working force by the practical man. But amongst your members there are many who are interested in the practical side of the why and the wherefore, and

also in the way and the means for escape from mental disease. As a practicing physician I recognize, as no doubt do you also, the helplessness of a part of the struggle, as well as the seriousness of the position, when we endeavor to so act as to employ prophylactic measures at the right time. Of some we are sure that the prophylaxis should have been applied to the ancestors, not to the hopeless degenerate who is an applicant for mental medication. The effects of alcohol, of syphilis, and of lust unbridled as well as bridled, leave such dire effects in the nervous system that moral and religious teachers, if heeded, would prove the best force to oppose to the growing tide of insanity.

I well recall the connection of medico-psychology years ago, when a commissioner of health of this city, and it became incumbent to secure a boat at short notice to transport patients with contagious disease. We had chartered the "Psyche" and had her sent from Greenport, Long Island. I received a telegram that "the *Physic* will arrive at four o'clock."

Gentlemen, I offer you a hearty welcome to our city, and I feel sure that should you desire to visit our hospitals, our penal or eleemosynary institutions, or our medical colleges, their medical officers would gladly aid you in furnishing you proper escort; and I have no less doubt that should you wish to study the seamy side of life, the physicians connected with the police department would aid you to make proper psychological studies without risk to your minds, morals or bodies.

With the best wishes of the medical profession of this city that you may have wise deliberations, that you may evolve very useful conclusions, that you may throw light upon the dark places in medico-psychology, and that in the study of the mind you may not neglect the body, but enjoy the pleasures of the sense, I bid you good morning.

The President responded as follows:

In the name of the Medico-Psychological Association I desire to thank Bishop Potter, who has welcomed us on behalf of the city, and Dr. Janeway, who has welcomed us on behalf of the medical profession. It seems to me extremely appropriate that the church and the profession of medicine should both be here to welcome us. There was a time when the church took upon herself the responsibility of taking care of the insane, or at least of ministering to the mind diseased. Sometimes the means employed were drastic, sometimes they were condemnatory, and many times I am afraid they did not tend to the amelioration of the condition of the patient. I am consequently glad that the actual care of the insane has been taken from the church and given to the medical profession. I believe that physicians are better able to deal with the physical condition of the insane than are the representatives of the church. I think, however, all agree that no profession devotes so much time and thought to the care of the insane, the unfortunate and the criminal, as does the clergy. I knew in a Western State a Bishop of a large diocese who, for many years, has spent a large part of his time in visiting institutions for the insane, poor-houses and prisons. There is no wiser administrator

or more self-sacrificing philanthropist than Bishop Gillespie, and there are many like him among the clergy of every denomination. Whenever we are in misfortune the church comes to our aid. We cannot forget, also, that we are a religious nation, and that the insane throughout the land require and appreciate the ministrations of the church. No individuals bring more comfort and hope to the insane than do ministers of the gospel. All praise to their self-sacrificing devotion.

We similarly feel that if it were not for the aid, counsel and moral support of the medical profession, our institutions for the insane would not be what they are.

The present system of care of the insane is the direct outgrowth of the efforts of the profession of medicine. It is also a great source of satisfaction to know that the past ten years have marked a period of what may be termed the hospitalization of institutions for the insane; in other words, that hospital methods have been adopted in place of custodial and asylum methods. In my opinion we are indebted for this improvement largely to the general medical profession. We are extremely fortunate in coming to New York, which no doubt is the medical center of the country. This Association was organized in Philadelphia in 1844. Four years later a meeting was held in New York City, in the Astor House, which I suppose was then the center of population. The meeting was not largely attended, and of those present not a single member survives. In 1852 a meeting was held in the Irving House. Where was the Irving House? I do not know. There is present but one man, Dr. Curwen, who was there then. In 1857 a meeting was held at the Metropolitan Hotel, and but three of those who attended survive—Dr. Bemis, of Worcester, Mass.; Dr. Van Deusen, of Kalamazoo, Mich.; and Dr. Curwen. In 1863 a fourth meeting was held also at the Metropolitan Hotel. Of our present members, two are here to-day who were present at that meeting—Dr. Curwen, of Warren, and Dr. Chapin, of Philadelphia. Thirty-six years have elapsed since the Association has met in New York, and this period has marked a very great development in the work of the Association. Thirty-six years ago it was an Association of Superintendents of the Institutions for the Insane, and its membership was confined largely to the Eastern States. The time and attention of the Association were largely concerned with the methods of housing and taking care of the insane. The good men who were interested in the Association were much exercised in the matter of buildings, and early adopted a series of propositions governing the uniform erection of all institutions for the insane. I am glad to say that the Association has long since outgrown all that. We are no longer concerned as an Association in any scheme of building, but we are becoming as liberal in the matter of buildings as our friends are in theology. Each member builds to suit himself, and no attempt is made to lay down any definite rules as to how the buildings for the insane shall be constructed. As an Association we are also concerned in the prevention of insanity and of those diseases which lead to insanity, and in devising methods to cure insanity where cure is possible. In addition to remedial and preventive measures,

we owe a duty to the public which in our zeal for the insane we may be in danger of losing sight of, to see that institutions for the insane are so economically administered that the people cannot say the burden of the support of the insane has become intolerable. As an Association we owe to the public to waste no money, but to do all our work in a humane, thorough-going way without extravagance, and at as little cost as is consistent with proper care. Beyond this we owe to the public—and I am glad to say that New York State is perhaps a more signal example of what is being done to fulfill this obligation than any other State—we owe to the public, I repeat, a careful study of all forms of mental disease, of the scientific aspects of insanity, of the causes of mental disease, and of diseased processes themselves, by which we may learn how to cure disease or limit its progress, if we may not wholly arrest the great flood of insanity which sweeps over the country. The study of these diseased processes in pathological institutes and out of them, according to scientific methods, is a duty and privilege of every member of the Association. We have come here to see what is being done, and I am sure that we shall have a very profitable meeting. I thank you for your kind attention and for your cordial welcome.

The Committee of Arrangements, through Dr. P. M. Wise, Chairman, reported as follows:

The Committee of Arrangements wishes to offer an explanation of the apparent lack of entertainment which you notice on the program. The one apology we have to offer is that we had presented many invitations to entertainments offered by the good people of New York and vicinity, but the Council vetoed them all. The only thing left is the boat-ride to-morrow afternoon. I expected that Dr. A. E. Macdonald would be here to explain very definitely how to get to the boat. We have thought, however, that we might, independent of the Council and in spite of that body, arrange an entertainment for you on Friday afternoon, and announce it now so that when you form your itinerary you can take this into consideration. I can assure you that these entertainments of the Association on Friday, after the Association has adjourned, have always been very pleasant, and those who have missed them have had reason to regret it. I will mention as an example the entertainment at Mt. Hope arranged by Dr. Hill of Baltimore. On Friday it is proposed to arrange for a special train or some special cars to go to the Bloomingdale Asylum, and Dr. Lyon, who is present, will give you the details. With regard to the other arrangements for the meeting, there is really nothing to report; they are simple and sufficiently explained by the program.

Letters were read by the Secretary from honorary members Dr. Jules Morel, Dr. V. Parant, and the Rev. J. M. Buckley. The Secretary also read letters and telegrams of regret from Drs. L. C. Mead, J. T. Searcy, and Michael Campbell.

Invitations were extended, through Dr. S. B. Lyon on the part of the Managers to visit the Bloomingdale Asylum at White Plains, and through Dr. B. D. Evans on the part of the New Jersey State Hospital at Morris Plains, to visit that institution.

The President appointed the following Nominating Committee: Dr. G. Alder Blumer, of New York; Dr. C. K. Clarke, of Ontario; Dr. W. F. Drewry, of Virginia.

Upon motion of Dr. Wise the members of the profession in New York City and the Managers of the State Hospitals of the State of New York were invited to accept seats throughout the sessions of the Association.

A recess was taken for the purpose of registration.

The following members were present during the whole or a part of the sessions:

Adams, Geo. S., M. D., Medical Superintendent, Westborough Insane Hospital, Westborough, Mass.

Allen, Henry D., M. D., Milledgeville, Ga.

Allison, Henry E., M. D., Medical Superintendent, Matteawan State Hospital, Fishkill Landing, N. Y.

Applegate, Chas. F., M. D., Assistant Physician, Iowa Hospital for the Insane, Clarinda, Ia.

Atwood, Charles E., M. D., Assistant Physician, Bloomingdale Asylum, White Plains, N. Y. (Associate Member).

Babcock, J. W., M. D., Medical Superintendent, State Hospital for the Insane, Columbia, S. C.

Babcock, Warren L., M. D., Assistant Physician, St. Lawrence State Hospital, Ogdensburg, N. Y. (Associate Member).

Baker, Lucius W., M. D., Riverview, Baldwinsville, Mass.

Ballintine, Eveline P., M. D., Assistant Physician, Rochester State Hospital, Rochester, N. Y. (Associate Member).

Bamford, Thomas E., M. D., Assistant Physician, Hudson River State Hospital, Poughkeepsie, N. Y. (Associate Member).

Bancroft, Charles P., M. D., Medical Superintendent, New Hampshire Asylum for the Insane, Concord, N. H.

Berkley, Henry J., M. D., 1303 Park Avenue, Baltimore, Md.

Beutler, William F., M. D., Wauwatosa, Wis.

Blumer, G. Alder, M. D., Medical Superintendent, Utica State Hospital, Utica, N. Y.

Bradfield, George Milton, U. S. A., Governor's Island, N. Y. (Associate Member).

Brink, Charles G., M. D., New York, N. Y. (Associate Member).

Brown, Willett S., M. D., Flushing, N. Y.

Brush, Edward N., M. D., Physician-in-Chief and Superintendent, Sheppard and Enoch Pratt Hospital, Towson, Md.

Bryant, Percy, M. D., Medical Superintendent Male Department, Manhattan State Hospital, Ward's Island, N. Y.

Buchanan, J. M., M. D., Medical Superintendent, East Mississippi Insane Asylum, Meridian, Miss.

Buckley, James M., D. D., LL. D., Morristown, N. J. (Honorary Member).

Burrell, Dwight R., M. D., Resident Physician, Brigham Hall, Canandaigua, N. Y.

Burgess, T. J. W., M. D., Medical Superintendent, Protestant Hospital for the Insane, Montreal, Quebec.

Burr, C. B., M. D., Medical Director, Oak Grove Hospital, Flint, Mich. (Secretary).

Campbell, Archibald, M. D., New York, N. Y. (Associate Member).

Carpenter, Eugene G., M. D., Superintendent, Columbus State Hospital, Columbus, O.

Channing, Walter, M. D., Private Hospital for Mental Diseases, Brookline, Mass.

Chapin, John B., M. D., Physician and Superintendent, Pennsylvania Hospital for the Insane, Philadelphia, Pa.

Chase, Robert H., M. D., Medical Superintendent, Friends' Asylum, Frankford, Philadelphia, Pa.

Christian, Edmund A., M. D., Medical Superintendent, Eastern Michigan Asylum, Pontiac, Mich.

Clarke, Charles K., M. D., Medical Superintendent, Rockwood Hospital for the Insane, Kingston, Ont.

Clark, Daniel, M. D., Medical Superintendent, Asylum for the Insane, Toronto, Ont.

Clark, Joseph C., M. D., Assistant Physician, Maryland Hospital for the Insane, Catonsville, Md. (Associate Member).

Cook, George F., M. D., Oxford Retreat, Oxford, Ohio.

Copp, Owen, M. D., Superintendent, Massachusetts Hospital for Epileptics, Palmer, Mass.

Courtney, J. Elvin, M. D., Assistant Physician, Hudson River State Hospital, Poughkeepsie, N. Y.

Cowles, Edward, M. D., Medical Superintendent, McLean Hospital, Waverley, Mass. (President, 1895).

Curwen, John, M. D., Medical Superintendent, State Hospital for the Insane, Warren, Pa. (President, 1894).

Dent, E. C., M. D., Medical Superintendent Female Department, Manhattan State Hospital, Ward's Island, N. Y.

Dewey, Richard, M. D. (formerly Medical Superintendent, Illinois Eastern Hospital for the Insane), Physician-in-Charge, Milwaukee Sanitarium, Wauwatosa, Wis. (President, 1896).

Dewing, Oliver M., Medical Superintendent, Long Island State Hospital, King's Park, N. Y.

Drew, Chas. A., M. D., Medical Director, Asylum for Insane Criminals, Bridgewater State Farm, Mass.

Drewry, W. F., M. D., Medical Superintendent, Central State Hospital, Petersburg, Va.

Edenharter, Geo. F., M. D., Medical Superintendent, Central Indiana Hospital for the Insane, Indianapolis, Ind.

Edgerly, J. Frank, M. D., Superintendent, Pennsylvania Epileptic Hospital and Colony Farm, Oakbourne, Pa.

Edwards, William M., M. D., Medical Superintendent, Michigan Asylum for the Insane, Kalamazoo, Mich.

Elliott, Hiram, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Elliott, Robert M., M. D., Medical Superintendent, Brooklyn Department of Long Island State Hospital, Brooklyn, N. Y.

Emerson, Justin E., M. D., Attending Physician, St. Joseph's Retreat, 128 Henry Street, Detroit, Mich.

Evans, B. D., M. D., Medical Director, New Jersey State Hospital, Morris Plains, N. J.

Ewing, W. Brown, M. D. (formerly Physician-in-Chief, State Asylum for the Chronic Insane), 515 Penn Avenue, Pittsburg, Pa.

Eyman, H. C., M. D., Medical Superintendent, Cleveland State Hospital, Cleveland, Ohio.

Ferguson, James F., M. D., Central Valley, N. Y.

Fisher, Theodore W., M. D. (formerly Medical Superintendent, Boston Lunatic Hospital), Boston, Mass.

French, Edward, M. D., Superintendent, Medfield Insane Asylum, Medfield, Mass.

Furness, William J., M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Givens, A. J., M. D., Stamford Hall, Stamford, Conn.

Gordon, W. A., M. D., Medical Superintendent, Northern Hospital for the Insane, Winnebago, Wis.

Gorton, Eliot, M. D., Assistant Physician, State Hospital, Morris Plains, N. J.

Granger, Wm. D., M. D., Vernon House, Bronxville, N. Y.

Gundry, Richard F., M. D., Richard Gundry Home, Catonsville, Md.

Guthrie, L. V., M. D., Superintendent, Second Hospital for the Insane, Spencer, W. Va.

Hancker, W. H., M. D., Medical Superintendent, Delaware State Hospital, Farnhurst, Del.

Harmon, F. W., M. D., Medical Superintendent, Longview Hospital, Carthage, Ohio.

Harrington, Arthur H., M. D., Medical Superintendent, Danvers Insane Hospital, Danvers, Mass.

Harris, Isham G., M. D., Assistant Physician, Hudson River State Hospital, Poughkeepsie, N. Y. (Associate Member).

Haviland, Clarence Floyd, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Heyman, Marcus B., M. D., Assistant Physician, Manhattan State Hospital, Central Islip, L. I., N. Y.

Hill, Charles G., M. D., Attending Physician, Mt. Hope Retreat, Baltimore, Md.

Hill, Gershom H., M. D., Medical Superintendent, Iowa Hospital for the Insane, Independence, Ia.

Hinckley, L. S., M. D., Medical Superintendent, Essex County Hospital, Newark, N. J.

Hoch, Aug., M. D., Assistant Physician and Pathologist, McLean Hospital, Waverley, Mass. (Associate Member).

Holt, John Milton, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Houston, John A., M. D., Medical Superintendent, Northampton Insane Hospital, Northampton, Mass.

Howard, A. B., M. D., Fair Oaks, Cuyahoga Falls, Ohio.

Howard, Eugene H., M. D., Medical Superintendent, Rochester State Hospital, Rochester, N. Y.

Howard, Herbert B., M. D., Massachusetts General Hospital, Boston, Mass.

Hughes, D. E., M. D., Chief Resident Physician, Philadelphia Hospital, Philadelphia, Pa.

Humphries, Henry Richard, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Hurd, Arthur W., M. D., Superintendent, Buffalo State Hospital, Buffalo, N. Y.

Hurd, Henry M., M. D. (formerly Medical Superintendent, Eastern Michigan Asylum), Baltimore, Md. (President, 1899).

Hutchinson, Henry A., M. D., Medical Superintendent, Western Pennsylvania Hospital for the Insane, Dixmont, Pa.

Hyde, Frank Gale, M. D., New York, N. Y. (Associate Member).

Jelly, George F., M. D., (formerly Medical Superintendent, McLean Hospital), 69 Newbury Street, Boston, Mass.

Kellogg, Theo. H., M. D. (formerly Medical Superintendent, Willard State Hospital), corner Riverdale Lane and Albany Post-road, Riverdale, New York, N. Y.

Kilbourne, Arthur F., M. D., Medical Superintendent, Rochester State Hospital, Rochester, Minn.

Kindred, J. J., M. D., River Crest, Astoria, Long Island, New York.

Knapp, John Rudolph, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Kulp, John H., M. D., Superintendent, Insane Department, Mercy Hospital, Davenport, Ia.

Langdon, Chas. H., M. D., Assistant Physician, Hudson River State Hospital, Poughkeepise, N. Y. (Associate Member).

Lawton, Shailer E., M. D., Medical Superintendent, Brattleboro Retreat, Brattleboro, Vt.

Logie, Benjamin Rush, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Lyman, William B., M. D., Superintendent, State Hospital for the Insane, Mendota, Wis.

Lyon, Samuel B., M. D., Medical Superintendent, Bloomingdale Asylum, White Plains, N. Y.

Mabon, William, M. D., Superintendent, St. Lawrence State Hospital, Ogdensburg, N. Y.

Macdonald, Alexander E., M. D., General Superintendent, Manhattan State Hospital, Ward's Island, N. Y.

MacDonald, Carlos F., M. D., Physician-in-Charge, Dr. MacDonald's House, Pleasantville, Westchester County, N. Y., and 85 Madison Avenue, New York.

MacGillvary, Stanley Howard, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Macy, William Austin, M. D., Medical Superintendent, Willard State Hospital, Willard, N. Y.

Magness, Frank Hosmer, M. D., Assistant Physician, Manhattan State Hospital, Hart's Island, N. Y. (Associate Member).

Meredith, Hugh B., M. D., Medical Superintendent, State Hospital for the Insane, Danville, Pa.

Meyer, Adolf, M. D., Pathologist, Worcester Insane Hospital, Worcester, Mass.

Miller, John F., M. D., Medical Superintendent, Eastern State Hospital, Goldsboro, N. C.

Mitchell, Thomas J., M. D., Medical Superintendent, Mississippi State Lunatic Asylum, Jackson, Miss.

Mooers, Emma W., M. D., Assistant Physician, Northampton Insane Hospital, Northampton, Mass. (Associate Member).

Moulton, A. R., M. D., Senior Assistant Physician, Pennsylvania Hospital for the Insane, Philadelphia, Pa.

Muir, A. Parker, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Murphy, John B., M. D., Medical Superintendent, Asylum for the Insane, Brockville, Ont.

Nairn, B. Ross, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Norris, Charles E., M. D., Central Islip, N. Y. (Associate Member).

Noyes, William, M. D., Superintendent, Boston Hospital, Mattapan, Mass.

Page, Charles W., M. D., Medical Superintendent, Connecticut Hospital for the Insane, Middletown, Conn.

Parsons, Ralph L., M. D. (formerly Medical Superintendent, New York City Asylum), Greenmont, near Sing Sing, N. Y.

Peterkin, Guy Shearman, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Peterson, Frederick, M. D., Instructor in Mental and Nervous Diseases, Columbia College, 4 W. 50th St., New York, N. Y.

Pettit, Louis C., M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Pilgrim, Charles W., M. D., Medical Superintendent, Hudson River State Hospital, Poughkeepsie, N. Y.

Powell, Theophilus O., M. D., Medical Superintendent, State Lunatic Asylum, Milledgeville, Ga. (President, 1897).

Prout, Thomas P., M. D., Assistant Physician, New Jersey State Hospital, Morris Plains, N. J. (Associate Member).

Ratliff, J. M., M. D., Superintendent, Dayton State Hospital, Dayton, Ohio.

Richardson, A. B., M. D., Medical Superintendent, Massillon State Hospital, Massillon, Ohio.

Richardson, Hubert, M. D., Pathologist, Mt. Hope Retreat, Baltimore, Md. (Associate Member).

Roberts, Linnaeus A., M. D., Assistant Physician, Boston Insane Hospital, Boston, Mass. (Associate Member).

Rowe, John T. W., M. D., Assistant Physician, Manhattan State Hospital, Hart's Island, N. Y. (Associate Member).

Runge, Edward C., M. D., Superintendent, City Asylum, St. Louis, Mo.

Ryon, Walter G., M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Sachs, B., M. D., 21 E. 65th Street, New York, N. Y.

Sanborn, Bigelow T., M. D., Medical Superintendent, Maine Insane Hospital, Augusta, Me.

Schmid, H. Ernst, M. D., White Plains, N. Y.

Scribner, Ernest V., M. D., Medical Superintendent, Worcester Insane Asylum, Worcester, Mass.

Sefton, Frederick, M. D., The Pines, Auburn, N. Y.

Smith, Geo. A., M. D., Medical Superintendent, Manhattan State Hospital, Central Islip, Long Island, N. Y.

Smith, Stephen, M. D., New York, N. Y. (Honorary Member).

Smith, S. E., M. D., Medical Superintendent, Eastern Indiana Hospital for the Insane, Richmond, Ind.

Spellman, Dwight Seymour, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Stathers, W. E., M. D., Superintendent, West Virginia Hospital for the Insane, Weston, W. Va.

Stedman, Henry R., M. D., South Street, Brookline, Mass.

Stranahan, J. O., M. D., Assistant Physician, Hudson River State Hospital, Poughkeepsie, N. Y. (Associate Member).

Taddiken, Paul Gerald, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Tobey, Henry A., M. D., Medical Superintendent, Toledo State Hospital, Toledo, Ohio.

Tomlinson, H. A., M. D., Medical Superintendent, St. Peter State Hospital, St. Peter, Minn.

Tracy, Ira O., M. D., Assistant Physician, Long Island State Hospital, Brooklyn, N. Y.

Turner, O. M., M. D., Assistant Physician, Mississippi State Lunatic Asylum, Jackson, Miss.

Van Gieson, Ira, M. D., Director, Pathological Institute, New York State Hospitals, No. 1 Madison Avenue, New York, N. Y.

Villeneuve, Georges, M. D., Medical Superintendent, Asile de Saint Jean de Dieu, Longue-Pointe, Que.

Wade, J. Percy, M. D., Medical Superintendent, Maryland Hospital for the Insane, Catonsville, Md.

Wagner, Charles G., M. D., Medical Superintendent, Binghamton State Hospital, Binghamton, N. Y.

Ward, John W., M. D., Medical Director, New Jersey State Hospital, Trenton, N. J.

White, M. J., M. D., Medical Superintendent, Milwaukee Hospital for the Insane, Wauwatosa, Wis.

Wickliffe, John Wakefield, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Wiley, Edward M., M. D., Lexington, Ky.

Wilsey, O. J., M. D., Physician-in-Charge, Long Island Home, Amityville, N. Y.

Wise, Peter M., M. D., President State Commission in Lunacy, No. 1 Madison Avenue, New York, N. Y.

Witmer, A. H., M. D., Assistant Physician, Government Hospital for the Insane, Washington, D. C.

Worcester, William L., M. D., Pathologist, Danvers Insane Hospital, Danvers, Mass.

Wright, Arthur Brownell, M. D., Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y. (Associate Member).

Other visitors and guests of the Association were as follows:

Dr. A. T. Hobbs, Assistant Physician, Asylum for the Insane, London, Ontario; Dr. Ales Hrdlicka, New York City; Dr. J. M. Lewis, Cleveland, Ohio; Orville F. Rogers, Trustee, State Hospital for the Insane, Danvers, Mass.; Dr. A. R. Defendorf, Pathologist and Assistant Physician, Connecticut Hospital for the Insane, Middletown, Conn.; Dr. T. P. Satterwhite, Pres. Board Com., Central Kentucky Insane Asylum, Lakeland, Louisville, Jefferson County, Ky.; Dr. Edward A. Everett, Assistant Physician, Middletown State Hospital, New York; Dr. M. C. Ashley, Assistant Physician, Middletown State Hospital, New York; Dr. Geo. E. Malsbary, Cincinnati, O.; Dr. Smith Ely Jelliffe, 231 W. 71st Street, New York; Dr. Andrew Macphail, Pathologist, Protestant Hospital for the Insane, Montreal; F. Asbury Awl, Secretary and Treasurer, Pennsylvania State Lunatic Asylum, Harrisburg, Pa.; Clark Bell, Esq., Editor *Med.-Legal Journal*, 39 Broadway, N. Y.; Dr. T. A. McGraw, Detroit, Mich.; W. G. Vinton, President Board of Directors, Oak Grove Hospital, Detroit, Mich.; Dr. Thos. S. Cullen, The Johns Hopkins Hospital, Baltimore, Md.; Dr. J. A. Boyle, Medical Interne, Manhattan State Hospital, Ward's Island, N. Y.; Dr. Wm. A. White, Assistant Physician, Binghamton State Hospital, Binghamton, N. Y.; Dr. Henderson B. Deady, Assistant in Pathology, Pathological Institute, New York State Hospital; Boris Sidis, M. A., Ph. D., Associate in Psychology, Pathological Institute, New York State Hospital; A. Bookman, Ph. D., Associate in Phys. Chem., Pathological Institute, New York

State Hospital; Dr. Harlow H. Brooks, Associate in Bacteriology, Pathological Institute, New York State Hospital; Stephen Muth, New York.

FIRST DAY—AFTERNOON SESSION.

The Association was called to order by the President at 3 p. m.

The following papers were read: "The Practical Value of Prophylaxis in Mental Disease," A. B. Richardson, M. D., Massillon, O.; discussed by the President. "Progress in the Clinical Study of Psychiatry," Edw. Cowles, M. D., Waverley, Mass.; discussed by Drs. Adolf Meyer and Charles G. Hill. "The Imagination in Relation to Mental Disease," R. H. Chase, M. D., Frankford, Philadelphia; discussed by Dr. Worcester. "Remarks on Mental Contagion and Psychopathic Infection, Inherited or Acquired, with Consideration of some Measures of Prevention of Insanity and Degeneracy," by Richard Dewey, M. D., Wauwatosa, Wis.; discussed by Drs. Runge, Eyman, Burr and Drew. "The Rôle of Wound Infection as a Factor in the Causation of Insanity," A. T. Hobbs, M. D., London, Ontario. "The Puerperal Insanities," H. A. Tomlinson, M. D., St. Peter, Minn. The discussion upon the last two papers was postponed until the evening session.

Adjourned.

FIRST DAY—EVENING SESSION.

The discussion of the papers by Dr. Hobbs and Dr. Tomlinson was participated in by Drs. Granger, Brush, C. F. MacDonald, Berkley, and by Dr. Tomlinson in closing. "Relations of Renal Disease to Mental Derangement," W. L. Worcester, M. D., Danvers, Mass.; discussed by Drs. Hubert Richardson, C. F. MacDonald, and by Dr. Worcester in closing. "Paretic Dementia—Its Etiology," Sanger Brown, M. D., Chicago (read by title). "Differential Diagnosis of Paretic and Pseudo-Paretic States," A. W. Hurd, M. D., Buffalo. "Lesions of the Intra-Cortical Vessels in Brain Syphilis and Paresis," by Henry J. Berkley, M. D., Baltimore. "Vocation and Paretic Dementia," by Jos. G. Rogers, M. D., Logansport, Ind. (read by title).

Adjourned.

SECOND DAY—MORNING SESSION.

The Secretary reported that the Council had recommended the following applications for membership:

For Honorary Membership.—Dr. Henry Hun, Albany, N. Y.; Dr. Antoine Ritti, Paris, France; Dr. J. B. Spence, Burntwood, Eng.; Dr. Alexander R. Urquhart, Perth, Scotland.

For Active Membership.—Dr. E. Stanley Abbot, Northampton, Mass.; Dr. William F. Beutler, Wauwatosa, Wis.; Dr. Willett S. Brown, Flushing, N. Y.; Dr. Lewis L. Bryant, Cambridge, Mass.; Dr. Eugene G. Carpenter, Columbus, Ohio; Dr. J. C. Corbus, Kankakee, Ill.; Dr. William E. Dold, Lake Geneva, Wis.; Dr. John C. Doolittle, Independence, Ia.; Dr. C. A. Drew, Bridgewater, Mass.; Dr. W. R. Dunton, Towson, Md.; Dr. James F. Ferguson, Central Valley, N. Y.; Dr. Austin Flint, New York City; Dr. L. V. Guthrie, Spencer, W. Va.; Dr. W. H. Hattie, Halifax, N. S.; Dr. S. S. Hill, Wernersville, Pa.; Dr. J. A. Houston, Northampton, Mass.; Dr. A. B. Howard, Cuyahoga Falls, O.; Dr. Geo. H. Knight, Lakeville, Conn.; Dr. William Wallace MacGregor, San Antonio, Texas; Dr. Dwight S. Moore, Jamestown, N. D.; Dr. Jason Morse, Pontiac, Mich.; Dr. I. H. Neff, Pontiac, Mich.; Dr. Thomas W. Reynolds, Hamilton, Ontario; Dr. Arthur C. Rogers, Faribault, Minn.; Dr. John Crayke Simpson, Washington, D. C.; Dr. George P. Sprague, Lexington, Ky.; Dr. O. M. Turner, Jackson, Miss.; Dr. F. S. Whitman, Elgin, Ill.; Dr. Edward M. Wiley, Lexington, Ky.; Dr. A. H. Witmer, Washington, D. C.

For Associate Membership.—Dr. James V. Anglin, Montreal, Que.; Dr. Jane Rogers Baker, Tewksbury, Mass.; Dr. Hunter Ashby Bond, New York, N. Y.; Dr. Charles G. Brink, New York, N. Y.; Dr. Albert Edward Brownrigg, Concord, N. H.; Dr. Archibald Campbell, New York, N. Y.; Dr. George B. Campbell, New York, N. Y.; Dr. John Howard Crosby, New York, N. Y.; Dr. W. H. Darling, St. Peter, Minn.; Dr. Arthur C. Delacroix, New York, N. Y.; Dr. Robert E. Doran, New York, N. Y.; Dr. Albert Durham, White Plains, N. Y.; Dr. Hiram Elliott, New York, N. Y.; Dr. T. F. Fitzgerald, Knoxville, Tenn.; Dr. Henry P. Frost, Buffalo, N. Y.; Dr. William J. Furness, New York, N. Y.; Dr. Arthur S. Hamilton, Independence, Ia.; Dr. Isham G. Harris, Poughkeepsie, N. Y.; Dr. Clarence Floyd Haviland, New York, N. Y.; Dr. Willis S. Hobson, Cleveland, Ohio; Dr. John Milton Holt, New York, N. Y.; Dr. Henry Richard Humphries, New York, N. Y.; Dr. Fannie C. Hutchins, Cleveland, Ohio; Dr. Anna E. Hutchinson, New York, N. Y.; Dr. Frank Gale Hyde, New York, N. Y.; Dr. James F. Kelly, Cleveland, Ohio; Dr. Walter H. Kidder, Ogdensburg, N. Y.; Dr. John Rudolph Knapp, New York, N. Y.; Dr. John M. Keyes, New York, N. Y.; Dr. Benjamin Rush Logie, New York, N. Y.; Dr. Stanley Howard MacGillvary, New York, N. Y.; Dr. Frank Hosmer Magness, New York, N. Y.; Dr. Charles Edwin Marshall, New York, N. Y.; Dr. H. Walter Mitchell, Bridgewater, Mass.; Dr. Reuben Fletcher Monette, New York, N. Y.; Dr. Emma W. Mooers, Northampton, Mass.; Dr. William B. Moseley, New York, N. Y.; Dr. A. Parker Muir, New York, N. Y.; Dr. B. Ross Nairn, New York, N. Y.; Dr. Charles E. Norris, Central Islip, N. Y.; Dr. Guy Shearman Peterkin, New York, N. Y.; Dr. Louis

C. Pettit, New York, N. Y.; Dr. John T. W. Rowe, New York, N. Y.; Dr. Walter G. Ryon, New York, N. Y.; Dr. Dwight Seymour Spellman, New York, N. Y.; Dr. Paul Gerald Taddiken, New York, N. Y.; Dr. Theodore Irving Townsend, New York, N. Y.; Dr. L. Walther, New York, N. Y.; Dr. John Wakefield Wickliffe, New York, N. Y.; Dr. Edward H. Williams, New York, N. Y.; Dr. Arthur Brownell Wright, New York, N. Y.

The report from the AMERICAN JOURNAL OF INSANITY was read by the Secretary and referred to the Auditors. Reports of the Secretary and Treasurer were read by the Secretary and referred to the Auditors.

The following report of the Nominating Committee was presented:

For President.—Joseph G. Rogers, of Indiana.

For Vice-President.—P. M. Wise, of New York.

For Secretary and Treasurer.—C. B. Burr, of Michigan.

For Auditors.—Thomas J. Mitchell, of Mississippi; Wm. Mabon, of New York.

For Councillors for Three Years.—C. P. Bancroft, of New Hampshire; H. A. Tomlinson, of Minnesota; G. F. Cook, of Ohio; A. W. Hurd, of New York.

Signed, G. ALDER BLUMER,
C. K. CLARKE,
W. F. DREWRY,
Nominating Committee.

Upon motion, duly seconded, the report of the Nominating Committee was unanimously accepted and adopted.

The privileges of the Lotos Club and of the Knickerbocker Club were extended to the Association.

A supplementary report of the Committee of Arrangements was made by Dr. Wise.

The following papers were read: "Our Work and Its Limitations," by E. C. Runge, M. D., St. Louis; discussed by Drs. Meyer, Worcester, A. B. Richardson. "The Legal versus the Scientific Test of Insanity in Criminal Cases," Carlos F. MacDonald, M. D., New York. "The Psychology of Criminals and a Plea for the Elevation of the Medical Service of Prisons," J. B. Chapin, M. D., Philadelphia.

The Association then adjourned to the steamer Wanderer lying at the foot of 34th street, on North River, for an excursion tendered by the managers of the Manhattan State Hospital, to Grant's tomb and the harbor, and afterwards to Ward's Island to

visit the two departments of the Manhattan State Hospital there located. Luncheon was served upon the steamer, and afterwards the entire party attended a lawn party tendered by Dr. and Mrs. A. E. Macdonald at their residence.

SECOND DAY—EVENING SESSION.

The Association convened at the Academy of Medicine, 17 W. 43d Street.

THE PRESIDENT:—One of our members is a pathologist, an alienist, a neurologist, a philanthropist and sometimes a poet. It gives me great pleasure to introduce Dr. Frederick Peterson, of New York, who will deliver the Annual Address, entitled "Some of the Problems of the Alienist."

The Annual Address was then delivered by Dr. Frederick Peterson, of New York.

DR. CHAPIN:—Mr. President, it is the unwritten law of our Association that the annual address is not a subject of discussion and that the orator shall have the largest liberty. The address which has been delivered is most helpful. Our orator has not scolded; he has not been pessimistic; he has not flared a danger torch. He has been gracious, he is optimistic, and now in the closing year of the century he shows himself a "pathfinder" of the coming century. I, therefore, rise to move that the Association tender to Dr. Frederick Peterson our thanks for the address he has delivered on this occasion.

The motion was adopted by a rising vote with applause.

Adjourned.

THIRD DAY—MORNING SESSION.

The report of Council was read by the Secretary, recommending the following applicants for membership:

Dr. Jos. D. Bryant ....New York.
Dr. Walter R. Gillette...............New York.
Dr. Allan McLane Hamilton.........New York.
Dr. Charles Inslee Pardee ....New York.
Dr. W. H. Ross..........Brentwood, New York.
Dr. Whitman V. White..............New York.

A communication was read by the President, from Dr. Simon Baruch of the Hydriatic Institute, extending an invitation to the Association to visit the Institute at 8.30 p. m.

The President appointed Drs. Lawton and Edwards tellers, to distribute and collect the ballots upon the applicants for membership recommended by the Council at the morning session of the previous day. The entire list was declared elected.

The following papers were read: "Judicial Errors in Lunacy," Geo. Villeneuve, M. D., and E. P. Chagnon, M. D., Longue-Pointe, Que.

Dr. Villeneuve prefaced his paper by these remarks: Coming after the paper of Dr. MacDonald read yesterday, the title of this paper might have been: A Study of the Practical Application of the Legal Test in Insanity and the Fitness of Judges to Detect and Define Insanity.

"Some Inconsistencies, Legal and Medical, J. T. Searcy, M. D., Tuscaloosa, Alabama (read by title). "Thyroid Extract—A Review of the Results Obtained in 1031 Collected Cases," William Mabon, M. D., and W. L. Babcock, M. D., Ogdensburg, N. Y., read by Dr. Babcock. The paper was discussed by Drs. C. G. Hill, A. B. Richardson, H. A. Tobey, and A. Hrdlicka. "Reflex Irritation with Especial Reference to Eye Strain—A Factor in Nervous and Mental Disease," Chas. A. Drew, M. D., State Farm, Mass. "Ephemeral Mania," T. J. W. Burgess, M. D., Montreal. "Disorders of Sleep among the Insane," Theo. H. Kellogg, M. D., New York. "The Care of the Insane in Farm Dwellings," G. Alder Blumer, M. D., Utica, N. Y.

Adjourned.

THIRD DAY—AFTERNOON SESSION.

The Association convened in the Pathological Institute of the New York State Hospitals, No. 1 Madison Avenue, at 3.15 p. m.

The following papers were read: "The Nature and Principles of Psychology," Boris Sidis, M. D., New York. "The Physiological and Morphological Basis of the Retraction Theory," Ira Van Gieson, M. D., New York. "The Retraction Theory from a Psychical Standpoint," William A. White, M. D., Binghamton, N. Y. "The Internal Structure of the Ganglion Cell," Stewart Paton, M. D., Baltimore, Md. "The Desirability of Close Connection between Psychological Laboratories and Hospitals for the Acute Insane," Samuel B. Lyon, M. D., White Plains, N. Y. (read by title).

Adjourned.

THIRD DAY—EVENING SESSION.

Upon motion the Secretary was authorized to cast the ballot for the election of the applicants for membership recommended by the Council at the morning session. The list was read by the Secretary and declared elected.

The Auditor's report was read by the Secretary.

The statement of the editors of the AMERICAN JOURNAL OF INSANITY, showing an itemized list of expenditures and vouchers for each account, has been examined and found correct.

Auditors: H. H. TOBEY,
May 25, 1899. CHARLES G. HILL.

The accounts of the secretary, including books showing receipts and vouchers showing for all expenditures, have been examined and found correct.

Auditors: H. H. TOBEY,
May 25, 1899. CHARLES G. HILL.

The discussion of Dr. Blumer's paper was participated in by Dr. Walter Channing and Mr. Clark Bell.

Dr. Paton's paper "On the Internal Structure of the Ganglion Cell," was discussed by Dr. Van Gieson.

Dr. Stephen Smith, of New York, an Honorary Member, was introduced by the President.

The following papers were read:

"The Pathology of Epilepsy, with an Introduction to a New Treatment," Chas. G. Hill, M. D., Baltimore.

"The Public Care of the Epileptic in Massachusetts," Owen Copp, M. D., Palmer, Mass.

"The Treatment of Epileptics in Colony," J. Frank Edgerly, M. D., Oakbourne, Pa.

"Deformities of the Palate," Walter Channing, M. D., Brookline, Mass.

A memorial notice of Dr. W. W. Godding was read by Dr. A. H. Witmer, of Washington.

Adjourned.

FOURTH DAY—MORNING SESSION.

The Association was called to order at 10 a. m.

The Committee on Manual reported verbally through Dr. Cowles as follows:

I regret the Committee is not able to report more progress, but we have not been forgetful of our interest in the subject. I am sorry some

other members of the committee are not here to sustain the statements I have to make to you. With the census that has been made of the schools of the country and later knowledge we have found that there are at least fifty established schools, or sufficiently established to be called training schools. In collecting data in regard to those schools and comparing what we got when we began, with the late information I have obtained from the men who are conducting schools energetically, there certainly has been very manifest progress, not only in founding training schools, but in enlarging and improving the character of training and a better understanding of its purposes and methods. I have gotten a very good impression of the zeal and enthusiasm with which the movement is being carried on by the men who know most about it and have become most interested in it. The difficulty has been, to which I think the members of our committee will testify unanimously, that the transitional state of the work has rendered it impossible to set up a standard. An attendant's manual written a few years ago, designed to meet the requirements of the schools then, would be somewhat obsolete now. The good schools have gone beyond the former standard. I speak of the larger schools in the great hospitals. There are difficulties to contend with, which cannot be appreciated without full conference with men engaged in the work of training attendants. So we all say as members of the committeee, so far as I have been able to confer with them, that it is right to have studied the question, to have been deliberate in arriving at a conclusion as to what is a reasonable standard to set up and as to what the studies shall be that the nurses are required to pursue. Another element is an important one, which concerns us directly, and that is the conditions of progress affecting the schools in the general hospitals. Within the last few years there has been a very decided tendency to increase the course of training from two to three years. The effect of this is to set up a standard which places them out of the grade of the nurses that we educate. The situation is bad enough at best and wrong enough as to the estimation in which the general hospital people hold our teaching and our graduates. It is all wrong, I am sure; they do not credit our nurses with the qualities which they possess. We must, consequently, be thoughtful in regard to the conditions which will keep our graduates abreast of those nurses in attendance at the general hospital schools. We may in fact need a somewhat elastic course rather than definite standards. I mention these points to show you that the problem is not entirely solved. It requires discussion and time, much more time than I had expected, to enable us to solve it. As a member of the committee, I will say that we have taken time, and we now feel that we should proceed to ask the Association to publish a manual in the coming year if we arrive at satisfactory results. In any event the members must be prepared for the future advancement of the work of training nurses and possibly early revisions. I can only report progress and make some more promises for the future.

Dr. Lyon:—I suppose everybody is aware of it, but they may not be, that the British Medico-Psychological Association has made a manual for schools which has met their approval. The schools are conducted under the authority of the State.

The President:—I wish to ask Dr. Cowles whether he desires to get the authority of the Association to print the manual when it is prepared.

Dr. Cowles:—I understand that we are empowered to publish the manual at our discretion.

It was thereupon resolved that the committee on training schools be empowered to publish their work under the auspices of the Council.

The following papers were read: "Metaphysics," H. C. Eyman, M. D., Cleveland (read by title). "The Importance of Better Co-operation and Organization Among Private Hospitals for the Insane," J. J. Kindred, M. D., Astoria, N. Y. (read by title). "The Brain of the Esquimaux," A. Hrdlicka, M. D., New York. "The Chemical Equivalent of Nervous Energy," S. Bookman, Ph. D., New York (read by title).

Upon motion, Dr. Frederick Peterson was elected a delegate to represent the American Medico-Psychological Association at the meeting of the British Medico-Psychological Association in July, and Dr. A. E. Macdonald to represent the American Medico-Psychological Association in the Psychological Section of the British Medical Association.

The Committee on History of the Association reported through Dr. Babcock as follows:

A year ago I took the liberty of preparing a brief paper, advocating the preparation of a history of the insane in America during the century just closing. The paper was brief, and, I am sorry to say, hastily written; and because of some emergencies I was not able to be present at St. Louis and present the paper myself. It was brought up there on the last day and I believe was not discussed. It seems to me a matter of justice to the men who have labored in the asylums through this century, that their work should be thoroughly brought out; there is no more important work that this Association could undertake and carry out to completion. I would recommend that the committee appointed last year be discharged and the whole matter be referred to the Council with power to act.

The President:—I understand the report of the committee to recommend that the committee be discharged and the whole matter be referred to the Council. Is it your intention that the Council shall report to a future meeting of the Association or shall have power to act on the matter?

Dr. Babcock:—I desire that the Council have full power to act on the matter.

Dr. Cowles:—I second the motion. The early work of our predecessors in this present century included a tremendous amount of hard work, sacrifice and patience, and the overcoming of great obstacles to develop the hospitals we see in the country to-day. A great deal of it will go into oblivion and not only not be appreciated but its effect on the public will be lost if we do not act who knew how it came about. I can see that it may be of special importance in our Southern States in immediate coming times, that the work done there be set forth in the way proposed. As I understand it, the idea is that the Council shall take charge of the whole matter and shall publish an adequate account, through proper editorship, of the history of the development and care of the insane during the past century, together with such biographical notices as shall seem proper to the Council.

The President:—It seems to me desirable, if this is referred to the Council, that the Council take the matter into immediate consideration. Councils, unfortunately, after an adjournment rapidly scatter.

Dr. Wise:—It occurs to me that there is a large amount of labor connected with this work, which the members of the Council may not find themselves able to do, and I think the Council should be empowered to employ a historian or some person to compile what is necessary from reports or other documents and to do other work necessary in getting this history in shape. I would, therefore, like to amend the report by giving the Council this authority, unless it has it at present.

Dr. Babcock:—It seems to me that the work will be of such character that no one man will be able to do it. To bring out the work properly in its proper relations, the history of the insane in different States should be prepared by men familiar with it and the whole subject should be referred back to the Council. I can see the necessity of having one man do the labor, and for that he should be paid and paid well. I consequently accept the

amendment of Dr. Wise, to give the Council authority to employ a historian.

The motion as amended was carried unanimously.

THE PRESIDENT:—We now come to the consideration of memorial notices. Because of the lateness of the hour, it seems proper that most of them be read by title, but one at least, that of our late Vice-President, Dr. Gilman, should be read in full. I will ask that that notice be read.

A memorial notice of Dr. H. A. Gilman was read by Dr. G. H. Hill, of Iowa.

The following memorial notices were read by title and referred to the Secretary: Dr. Foster Pratt, of Michigan, by Dr. W. M. Edwards; Dr. Jno. B. Hamilton by Dr. H. M. Bannister; Dr. Geo. H. Rohé by Dr. J. Percy Wade, and Dr. W. A. Gorton by Dr. A. H. Harrington.

Upon motion of Dr. E. A. Christian the thanks of the Association were extended to the Committee of Arrangements, to the Lotos Club and the Knickerbocker Club for hospitalities extended to the Association, to the Hospitals in New York, to the Managers of the Manhattan State Hospital, the Bloomingdale Asylum and the New Jersey State Hospital at Morris Plains for courtesies, to the Pathological Institute of the New York State Hospitals, to the Academy of Medicine for the use of the hall; to Dr. Simon Baruch of the Hydriatic Institute and to the press for courtesies and to the retiring President for his courteous presiding over our meeting.

THE PRESIDENT:—It now becomes my duty to express to you, the members of the Association, my sincere thanks for your great kindness to me during the time I have acted as President. I feel that we have had extremely interesting and profitable sessions, and that the present meeting marks the high-water mark of our scientific work. I have a feeling that year by year there has been an improvement in the character of the work done by the Association. I have been present at many meetings and I do not now recall any in which the papers presented and the discussions so well indicated that we had entered upon an era of scientific and thorough work, as at this meeting. I thank you from the bottom of my heart for the kindness you have shown me. I declare the meeting adjourned to meet in Richmond, Va., in the year 1900.

Adjourned. C. B. BURR, Sec'y.

ENOCH PRATT TO SHEPPARD ASYLUM

DECISION OF THE MARYLAND COURT OF APPEALS MAINTAINING THE VALIDITY OF THE BEQUEST OF ENOCH PRATT TO THE SHEPPARD ASYLUM.

Those of our readers who have followed the course of the litigation to establish the right of the Sheppard Asylum to the liberal bequest made by the late Enoch Pratt will be interested to learn from the annexed opinion of Chief Justice McSherry of the Maryland Court of Appeals, that the contention of the Sheppard trustees has been maintained in every particular by the highest court.—Editors.

COURT OF APPEALS OF MARYLAND.

ISAAC PRATT, Jr. AND SUSANNA K. TOBEY.

vs.

THE TRUSTEES OF THE SHEPPARD AND ENOCH PRATT HOSPITAL et al.

(October Term, 1898.—Filed Dec. 21, 1898.)

Two appeals in one record from the Circuit Court No. 2 of Baltimore City.

W. Irvine Cross for the appellants.

William Pinkney Whyte, Willis & Homer, Barton & Wilmer for the appellees.

Argued before McSherry, C. J., Briscoe, Bryan, Pearce, Page, Boyd, Fowler, JJ.

McSherry, C. J.—In these proceedings the validity of the twelfth, or the residuary, clause of the will of the late Enoch Pratt is assailed by his heirs-at-law and next of kin, by his alternative residuary legatees and devisees. There are four cases which have been consolidated, but it is not necessary to set forth the pleadings, or any parts of the pleadings therein, as the disposition of the questions presented for decision depends

largely on the terms of the will. The cases have been argued with marked zeal and ability on both sides, and we have been greatly aided by the discussion at the bar in our examination of the matters in controversy.

The clause in dispute is in these words: " Having in my lifetime liberally provided for my niece and nephews hereunder named, I do now hereby give and devise and bequeath all the rest and residue and remainder of my estate of every kind and description, whether real, personal or mixed, and wherever the same may be situate of which I may die possessed or be in any way entitled to at the time of my death, after the payment of all debts justly due by me, and after satisfying all the devises and bequests hereinbefore set forth, to The Trustees of the Sheppard Asylum, a corporation duly incorporated by the General Assembly of the State of Maryland by said name, style and title, and its successors forever, it being my intention and meaning to make said corporation, The Trustees of the Sheppard Asylum, the residuary legatee and devisee under this my last will and testament.

" And I direct my executors to set over, transfer and convey by proper deeds, assignments and transfers, the said residuary of my estate to the said corporation, upon and subject, however, to the following condition and bargain, namely: That the said trustees shall adopt as the name and style of said corporation the title of 'The Trustees of the Sheppard and Enoch Pratt Hospital,' and shall obtain at the first session of the General Assembly of Maryland after my death an amendment to their charter authorizing the said change of title and adopting the said name of the 'Trustees of the Sheppard and Enoch Pratt Hospital' as the future title of said corporation.

" While I do not wish to alter the operations and management in the working of the said Asylum as now existing and being carried on, it is my wish and will that the income from my said residuary estate shall be used to complete the present buildings and grounds, and for the erection of such other buildings or building as will accommodate not less than two hundred additional inmates, and after that the income from my aforegoing donation shall be devoted mainly to the care of the indigent insane in the most advisable manner at *very low charges* or absolutely *free*, as the trustees of said corporation in the exercise of their best judgment as to the rate to be charged may deem best and wisest to promote the object of this donation.

" Provided, however, and it is expressly my will, that in case the said Trustees of the Sheppard Asylum fail to obtain from the General Assembly of Maryland at its first session after my death the amendment to the charter of said institution hereinbefore stipulated and provided for, and fail to adopt the name for said corporation of the 'Trustees of the Sheppard and Enoch Pratt Hospital,' then and in that case it is my will, and I then give, devise and bequeath in lieu of the aforegoing provision, the said residue of my estate to my niece Ellen J. O. Phinney, and to my nephews, Gerard C. Tobey, Horace P. Tobey, J. Lowell Pratt, David G. Pratt, Edmund T. Pratt and Moreland L. Pratt, to be in that case set

apart for and equally divided among them and the issue *per stirpes* of any of them who may be dead at the time of my decease, such issue to take the share to which its or their parents would, if living, have been entitled.

"I direct my executors, until it shall have been decided as above provided, whether the said condition of my aforegoing devise and bequest of said residue will be performed, that is to say, whether the said corporation will obtain authority as aforesaid to change its title, and will in fact adopt the title above designated—to keep all buildings and improvements on my property insured and in good order and condition, and pay all charges and taxes thereon, and to collect the rents and income of said residue of my estate, and to invest the said net income in Baltimore City stock, the same to be added to and constitute a part of the said residuary estate."

Mr. Pratt died in September, eighteen hundred and ninety-six. At the January Session, eighteen hundred and ninety-eight of the General Assembly of this State a statute was enacted changing the corporate name of the Trustees of the Sheppard Asylum to "The Trustees of the Sheppard and Enoch Pratt Hospital," and this change was agreed to by the body corporate. The condition, and the sole condition, prescribed in the twelfth clause of the will having been complied with, it is now insisted: *First;* That the residuary clause creates a trust which is void because so vague and uncertain as to the objects to be benefited that it cannot be enforced, and that therefore, the next of kin and heirs-at-law—a brother and a sister of the testator—are entitled to the property constituting the residuum: *Secondly;* That the residuary clause creates a perpetuity and is therefore void: *Thirdly;* That the *Act of 1898, Ch. 17,* changing the name of the Sheppard Asylum to the Sheppard and Enoch Pratt Hospital, is unconstitutional and void, and that, therefore, the residuary estate passed to the alternative residuary legatees and devisees—a niece and six nephews. The last position will be considered in the next succeeding case. As the second proposition is dependent entirely upon the disposition which may be made of the first one, we now proceed to examine and consider the first contention.

It is safe to say that thousands of cases have been decided where the same or synonymous words in different wills have, in view of the unlike circumstances attending their use and the contrariety of the contexts where they are found, received different, and often widely different, interpretations; and it has, in consequence, frequently been observed that the effect given or the meaning ascribed to a particular word in the construction of one will is by no means a sure guide for its application or a reliable definition of its meaning when used in an apparently similar clause of some other individual's will. And this, of necessity, must be true when we take into account the diversity of the subject dealt with; the inequality in the capacity of the testators to clearly express their intentions; the flexible character of almost every word in a living and a constantly changing language; and the numerous and dissimilar designs and motives revealed in testamentary dispositions. If, without first find-

ing from the four corners of the instrument what the testator's purpose or intention really was, we turn for its ascertainment to the multitude of adjudged cases wherein the words he has used have been given a meaning in other wills, his design may be easily frustrated, and though perfectly plain in itself, might and most probably would be so shrouded in obscurity as to be hopelessly unintelligible. It is not meant by what has just been said to intimate that there are no established or recognized rules or canons of construction to which resort may be had in cases of doubt or difficulty to solve a seeming uncertainty. These rules or canons are invoked not to defeat, but to give effect, when possible, to the expressed intention. To avoid misunderstanding it may not be amiss to remark that we distinguish between rules of construction which are appealed to with a view of upholding an intention and rules of policy or of property which cannot be disregarded even though they defeat the most clearly stated purpose.

If we lay out of view for the moment all canons of construction, and critically read the words of the clause in controversy—for the simplest and most obvious method of discovering the intention of a testator, is to read the language he has employed to give expression to that intention—his purpose is clearly manifested; and if that purpose, thus declared, does not invade some rule of property, or is not repugnant to some settled policy of the law, it ought to, and certainly will, prevail. What, then, has he said?

He starts with the assertion that he had in his lifetime liberally provided for his niece and nephews, who are the alternative residuary legatees and devisees. That he did do this is abundantly clear from the evidence. To each of the six nephews and to the niece, and to another nephew who was not named as an alternative legatee, he gave in eighteen hundred and ninety-two, $200,000, or $1,600,000 in the aggregate. He, therefore, did not intend that they, or the appellants in this case who are not mentioned in the will, should receive any part of the estate disposed of by the residuary clause, unless as respects the alternative residuary legatees and devisees, the condition on which the gift to the Sheppard Asylum was made to depend should fail to be complied with by the omission of the legislature to change the name of the Asylum to the Sheppard and Enoch Pratt Hospital. We begin, then, with the postulate—and an obvious postulate it is—that the testator did not design these contesting parties to have any portion of his residuary estate at all; and if by reason of an interpretation that may be placed on his will, they do succeed to it, they will get it in spite of his unmistakable intention that they should not possess or enjoy any part or parcel of it whatever. But it is equally clear that he intended the Sheppard Asylum—a corporation "*its successors forever*"—to have and to hold this residuum; for he explicitly declares, "it being my intention and meaning to make said corporation, the Trustees of the Sheppard Asylum, the residuary legatee and devisee under this my last will and testament." Nor does he stop with that emphatic declaration, for he follows it with a specific instruc-

tion to his executors "to set over, transfer and convey by proper deeds, assignments and transfers the said residue of my estate to the said corporation, upon and subject, however, to the following condition and bargain"; and then comes the provision with respect to the change of name. If the clause had stopped here, there can be no pretence that an absolute estate in the personalty and a fee in the realty had been given, dependent on the single condition in regard to the change of the name; and when that condition was complied with by the passage and acceptance of the *Act of 1898, Ch. 17*, the title—assuming the clause had stopped as just indicated—would have become indefeasible, provided the statute is valid and free from constitutional objections. It is too clear for discussion that up to this point of the clause Mr. Pratt obviously intended the Sheppard Asylum to take by deeds, transfers and assignments from his executors, and not immediately under the will alone, the whole and entire interest and estate which he himself had in the residuary property. He gave it to the Sheppard Asylum upon a condition, a bargain; and when that condition and bargain had been complied with and entered into, the corporation was in a condition to enforce a conveyance and transfer from the executors to itself. The gift being upon a single condition and bargain, and being made in terms that import an absolute donation upon a compliance with the condition and a performance of the bargain, it is not to be assumed, in the absence of an express declaration, certainly not upon a bare construction, when later on he uses words looking to the disposition to be made of the *income* that may arise from the donation, that he intended by those words to convert the original gift into a gift merely in trust—to cut down the absolute estate by engrafting on it *through the income* an imperative trust—particularly when the words thus relied on to accomplish that result are capable of an interpretation which will not bring about such a palpable conflict or inconsistency in one and the same clause of the will.

There is a peculiar significance in the use of word "bargain" as indicating the nature of the estate given by the residuary clause. The gift is made upon something more than an ordinary condition, for the condition is coupled with a term that imports the characteristics and the elements of an obligatory contract. The testator contracts—he bargains—to give the Sheppard Asylum the residuum of his estate provided the trustees agree to include his name in the title of the body corporate. The Trustees of the Sheppard Asylum are to become the owners of the property for and upon the consideration which he specifically named. Can it be doubted or questioned when this bargain was closed—offered by him and accepted by the body corporated and sanctioned by the General Assembly—that the right of the corporation to possess and enjoy as its own the fruits of the contract was complete? If this right was complete and perfect, as we think it manifestly was, then a beneficial, an actual ownership must have been intended by the testator to be vested in the Sheppard Asylum; and it took, or was designed to take, an absolute estate.

After making this absolute donation the testator declared that whilst he did not wish to alter the operations and management in the working of the Sheppard Asylum as then conducted, "it is my *wish and will* that the income from my residuary estate shall be used to complete the present buildings and grounds and for the erection of such other buildings or building as will accommodate not less than two hundred additional inmates, and after that the income from my aforegoing donation *shall* be devoted *mainly* to the care of the indigent insane in the most advisable manner at very low charges or absolutely free, as the trustees of said corporation in the exercise of their best judgment as to the rate to be charged may deem best and wisest to promote the object of this donation." This is the clause, which, it is claimed, creates a trust, and was intended to create a trust; and which trust when created, it is further insisted, is void for uncertainty. We are thus brought face to face with the question: Does this clause, located as it is, following a gift that is unmistakably absolute, cut down the estate thus given to a trust estate? Does the clause raise an imperative trust? As we have said, and now repeat, it cannot be assumed in the absence of an express declaration that the testator meant to undo what he had just done—that he intended to convert what he was so careful to describe as an absolute estate into one far different and less unlimited. He has not *said* that he gave the donation upon trust. He has said all he well could say to indicate the contrary. If, however, a trust has been created we find no manifestation of an intention to create it, unless the words "it is my *wish* and *will*" and the words "*shall* be devoted," furnish sufficient evidence of such a purpose. The effort, therefore, is to thrust upon this clause a construction that will make it create a trust, and then to have the trust so raised by construction declared void; and thus to defeat *in toto* what the testator has declared to be his donation to the Sheppard Asylum. Now, how is this sought to be accomplished?

With great diligence, zeal and ability vast numbers of cases construing the words "wish" and "will" and kindred words have been collected on the briefs. In those cases these words and similar ones have been held to create trusts, and it is contended they accomplished that result here. It is undoubtedly true that those and other like precatory words will, under conditions, but not invariably, raise or imply a trust. It would be an almost endless, as it certainly would be a wholly unprofitable, task to enter upon an examination of these numerous cases. The whole question is one of the interpretation of each particular will. Whilst the doctrine is settled that precatory words may raise a trust, the application of the doctrine to individual cases depends entirely upon the provisions of each separate will. Negro Chase vs. Plummer, 17 Md. 177. "Precatory words may be used which, standing alone, would, under the decisions, create a trust, but they may be qualified and controlled by other expressions showing that the gift is absolute, and that everything is left to the discretion of the devisee or legatee." 2 Pom. Eq. Sec. 1016: "Expressions sufficient *per se* to create a trust may be deprived of their effect by

the context expressly declaring, or by implication showing, that no trust was intended." 1 Jar. on Wills (5th An. Ed.), star p. 385. "In some cases where the strongest terms were employed relief has been denied," that is, a trust has not been declared. Negro Chase vs. Plummer, supra.

Whatever may have been the results reached in the earlier cases on this subject, there is a strong tendency nowadays to restrict the doctrine of precatory trusts within more reasonable and somewhat narrower bounds than formerly; and Mr. Pomeroy states that upon the authority of more modern decisions the whole doctrine may be summed up in a single proposition. And this is the proposition which he announces: "In order that a trust may arise from the use of precatory words, the court must be satisfied from the words themselves taken in connection with all the other terms of the disposition *that the testator's intention to create an express trust was as full, complete, settled and sure as though he had given the property to hold upon a trust declared in express terms in the ordinary manner*. Unless a gift to *A* with precatory words in favor of *B* is in fact *equivalent in its meaning, intention and effect* to a gift to *A* 'in trust for *B*,' then certainly no trust should be inferred." 2 Pom. Eq., Sec. 1016. The same doctrine is stated in Story Eq. Jur., Sec. 1069, in this way: "Accordingly, in more modern times, a strong disposition has been indicated not to extend this doctrine of recommendatory trusts; but as far as the authorities will allow, to give to the words of wills their natural and ordinary sense, unless it is clear that they are designed to be used in a peremptory sense."

Whether or not a trust has been created in any given case by the use of precatory words is, in the last analysis, a question of construction and interpretation to ascertain the *intention*.

Did the testator by the use of the words he employed *intend* to create a trust? "The effect of expressions of this nature in creating a trust depends entirely on the *supposed intention* of the donor (or testator) to be gathered from the tenor of the instrument." Hill on Trustees, 114, quoted with approval in Williams vs. Worthington, 49 Md. 579.

In Sale vs. Moore, 1 Sim. 534, Sir Anthony Hart, V. C., said: "The first case that construed words of recommendation into a command made a will for the testator, for every one knows the distinction between them." In Wright vs. Atkyns, 1 Ves. & B. 313, Lord Eldon remarked: "This sort of trust is generally a surprise on the intention, but it is too late to correct that now." In Meredith vs. Heneage, 1 Sim. 543, Chief Baron Richards, in commenting on prior decisions, observed: "I entertain a strong doubt whether in many or perhaps most of the cases, the construction was not adverse to the real intention of the testator. It seems to me very singular that a person who really meant to impose the obligation established by the cases should use a course so circuitous and a language so inappropriate and obscure to express what might have been conveyed in the clearest and most usual terms—terms the most familiar to the testator himself and to the professional or other person who might prepare his will. In considering these cases it has always occurred to

me that if I had myself made such a will as has generally been considered imperative, I should never have intended it to be imperative; but, on the contrary a mere intimation of my wish that the person to whom I had given my property should, if he pleased, prefer those whom I proposed to him, and who, next to him, were at the time the principal objects of my regard."

It certainly seems singular that a testator having a *full and settled intention to create a trust* (for that is what must be read on the face of the will or no trust can exist) should adopt a mode which at best appears to be a mere suggestion or inference, instead of employing the familiar method and creating the trust by an express declaration. And this becomes even more singular when we find in the third clause of this identical will that a trust *is* created by the use of apt and appropriate words. Had Mr. Pratt intended to give this residuum in trust he could have used precisely the words he employed in the third clause where he designed to found a trust. "It can scarcely be presumed that every testator should not clearly understand the difference between such expressions (precatory words) and words of positive direction and command; and that in using the one and omitting the other he should not have a determined end in view." Story Eq. Jur., Sec. 1069.

If there be one thing settled on this subject of the effect of precatory words, it is that such words are not always imperative. "They are deemed to be flexible in character and must yield, if the imputed interpretation be against the rules of law *or so inconsistent with other* provisions of the will that both cannot stand together." Negro Chase vs. Plummer, supra. "Where the words of a gift expressly point to *absolute* enjoyment by the donee himself, the natural construction of subsequent precatory words is that they express the testator's belief or wish without imposing a trust." 1 Jar. on Wills (5th Am. Ed.), star page 389. Now we are at a loss to see how Mr. Pratt could well have given a more absolute estate in this residuum to the Sheppard Asylum than he did give in the beginning of the twelfth clause. There is not only no suggestion of a trust in the donating words, but the very scheme of the gift and the particular method prescribed for the conveyance and transfer of the property by the executors to the beneficiary, forbid the inference that these deeds or transfers were to contain provisions fettering the estate with any trust whatever. Obviously he intended the Asylum to hold mediately under the will, immediately under the conveyances and transfers, and he gave no intimation that anything less than the unlimited estate, unclogged by any trust, should be conveyed and transferred by his executors. The words of the gift—that is, the effective donating words—unequivocally point to an absolute enjoyment of the property by the donee, and in this important respect they radically differ from the language in Maught vs. Getzendanner, 65 Md. 527, where this court said: "It is manifest from the whole will that the testator never intended to give him (the legatee) this property in his own right and for his own use." At the very threshold of the residuary clause we are confronted by an absolute gift, and if

the subsequent provisions of the same clause create, by the use of the precatory words alluded to, a trust that qualifies the antecedent gift, there is a palpable repugnance in the same clause. Such a repugnance is indicative of an intention not to create a trust: and when an intention not to create a trust is manifested, in this or in any other way, subsequently precatory words are to be interpreted not as cutting down the prior absolute gift, but as expressive of the testator's wish and desire, without imposing an imperative direction.

We have heretofore remarked and we now repeat that no inflexible meaning has ever been, or possibly can be, ascribed to any precatory word, whereby that word whenever it happens to be used in a testamentary paper, must invariably be given precisely the same and no different effect. Indeed, as observed by Pollock, C. B. in *Reg. vs. Skeen, Bell, C. C.*, 97, "there is no word in the English language which does not admit of various interpretation." The varying circumstances in which it is employed give rise to its various meanings. The character of the estate given to the first taker is always a consideration of much significance in determining whether the words relied on to create a trust are recommendatory or imperative. Accordingly a distinction is drawn between cases where the gift to the first devisee is for life only and those in which the gift is absolute with superadded words, Howarth vs. Dewell, 6 Jur. (N. S.) 1360; McClernan vs. McClernan, 73 Md. 287; and precatory words which in the one case would create a trust would be insufficient to do so in the other. We are dealing now with an absolute gift followed by precatory words.

But in addition to this: "In ascertaining whether the precatory words import merely a recommendation or whether they import a definite, imperative direction (to the legatee) as to his mode of dealing with the property, the court will be guided by the consideration whether the amount he is requested to give is certain or uncertain, and whether the objects to be selected are certain or uncertain; and if there is a total absence of explicit direction as to the *quantum* to be given, or as to the objects to be selected by the donee of the property, then the court will infer from the circumstances of the testator having used precatory words expressive only of hope, desire or request, instead of the formal words usual for the creation of a trust, that those words are used, not for the purpose of creating an imperative trust, but simply as suggestions on the part of the testator for the guidance of the donee in the distribution of the property." 1 Jar. on Wills (5th Am. Ed.), star page 396-397. In the celebrated case of Morice vs. Bishop of Durham, 10 Ves. 522, Lord Eldon held that the indefinite nature and *quantum* of the subject, or the indefinite nature of the objects referred to in a will not expressly creating a trust, is always used by the courts *as evidence* that the mind of the testator was not to create a trust, or, as somewhat differently stated in Handley vs. Wrightson et al., 60 Md. 198, precatory words will create a trust where the testator has pointed out with clearness and certainty the objects of trust, and the subject-matter on which it is to attach, when

the contrary intention does not appear from the context or by necessary implication.

But it must be borne in mind that there is a distinction between a trust that is void for uncertainty, and an uncertainty that is simply indicative of the absence of an intention to create a trust. In the one case there is no uncertainty as to the intention to create a trust, but merely an uncertainty as to the objects to be benefited or the subject to be affected; in the other case, there is simply an uncertainty as to whether any trust was intended to be created at all. If it be uncertain as to whether there was an intention to create a trust, it is obviously not the province of the courts to engraft a trust upon the gift; but if it be apparent from the whole will that a trust was intended to be established, then the uncertainty as to the objects or the subject of that trust, will not indicate that there was no intention to raise a trust, but the uncertainty will avoid the trust attempted to be founded. Where the expressions have been held too vague to show an intention to create a trust, the devisee or legatee retains the property for his own use; but where the intention to create a trust is sufficiently expressed, and yet the objects or the subjects of it are uncertain, the gift fails, and the heir or next of kin is let in to the beneficial ownership. It is precisely this distinction that runs through all the Maryland cases from Tolston vs. Tolston, 10 G. & J., 159, where the doctrine of precatory trusts was first recognized, in its broadest form in this State, down to Nunn vs. O'Brien, 89 Md. 198, the latest decision, and one more in accord with the modern tendencies of the courts on this subject. So in Saylor vs. Plaine, 31 Md. 158, and in Maught vs. Getzendanner, 65 Md. 527, the intentions to create trusts were both obvious and apparent, but the objects were uncertain in both instances. The trusts consequently failed and as it was clear in each case that the legatees named were not designed to have any beneficial interest in the legacies, the next of kin took the property. It may, therefore, be regarded as established and settled in this State that where a trust is specifically and clearly intended to be created and there is an uncertainty in the objects to be benefited or in the subject to be affected, the trust will fail and the next of kin will be entitled to the legacy. Dashiell vs. Attorney-General, 6 H. & J. 1; Wildeman vs. Mayor &c., Balto., 8 Md. 551; Church Extension vs. Smith, 56 Md. 362; Yingling vs. Miller, 77 Md. 104. These were all cases where there was no doubt that trusts were intended to be created. Apt words were used for that purpose, but because the objects were indefinite the trusts failed. We do not question the doctrine—we distinctly reaffirm it. But where it is sought to show by implication or from the use of precatory words, following an absolute gift, that a trust was intended to be fastened on the gift, an uncertainty as to the objects or as to the subject of the alleged trust will be a reason, not necessarily conclusive, but still a reason, for holding that no trust was designed by the testator. This is very clearly stated by Lord Chancellor Truro in Briggs vs. Penny, 3 Mon. & G. 546: "It is most important," he remarked, "to observe that vagueness in the object will unquestionably

furnish reason for holding that no trust was intended, yet this may be countervailed by other considerations which shows that a trust was intended, while at the same time such trust is not sufficiently certain and definite to be valid and effectual * * *." See too Williams vs. Worthington, supra.

Now it is contended that the direction to apply certain portions of the income "mainly to the care of the indigent insane, in the most advisable manner, at very low charges or absolutely free, as the trustees of said corporation in the exercise of their best judgment as to the rate to be charged, may deem best and wisest to promote the objects of this donation," is so vague and indefinite as not to be capable of being enforced; and it is insisted as this direction follows the words "it is my wish and will"; a trust was attempted and was intended to be created for indefinite objects, and that the next of kin and heirs-at-law are entitled to the property.

If it be conceded that the objects of the alleged trust—the indigent insane—are uncertain, it by no means follows that the residuary clause must be stricken down. And it does not follow that the residuary clause must be stricken down, because no matter how indefinite the term "indigent insane" may be, that indefiniteness will not affect the prior absolute gift, unless instead of being an absolute gift it was merely a gift in trust for the indigent insane. The intention to create a trust for the indigent insane must first clearly appear as in Dashiell vs. Attorney-General, or in Maught vs. Getzendanner, and it must also be manifest that the legatee—The Sheppard Asylum—was not designed to have a beneficial interest as in Saylor vs. Plaine, before the mere vagueness of the objects can strike down the antecedent absolute gift. But the very question at issue is whether a trust was *intended* to be raised; and to invalidate the whole bequest because the objects of the alleged trust are indefinite, before determining that there is a trust at all, is to assume the existence of the very matter in dispute—the precise thing that is controverted. Obviously wherever, as here, there is an unqualified, absolute gift (as this became after the adoption and acceptance of the *Act of 1898, Ch. 17*, treating that act as valid), and it is alleged that that gift has been cut down by the superaddition of precatory words and converted thereby into a trust estate; the fact that there is no sufficient designation or description of the objects of the trust, naturally suggests, not the inference, that there was an attempt to create an unenforcible trust; but, on the contrary, leads to the conclusion that no trust at all was intended, and that therefore the precatory words were used to indicate that the testator designed to communicate a discretion and not to impose an obligation. This process of reasoning does not uphold a trust that is invalid because it is invalid; but it refuses to convert by construction an absolute gift into one upon trust, when from the vagueness of the alleged trust it is apparent the testator never designed to create any trust whatever. It appeals to the uncertainty of the alleged trust to show that no trust was contemplated. Always bearing in mind that there is apparent on the face of the will a

purpose that the legatee shall take a beneficial interest in the legacy, and that there is no explicit declaration of a trust coupled therewith, there is nothing in sound reason and no principle in the decided cases to preclude a resort to the uncertainty of the alleged trust for evidence apparent on the face of the will itself, that the testator did not intend to declare a trust. The very uncertainty appealed to to defeat the donation is, therefore, under the terms of this particular will, a cogent reason for holding that no trust was intended to be created at all.

"It may be laid down, however, as well settled upon all the authorities, that in order to justify the court in construing precatory words in a will as creating a trust, it must appear that the property which is the subject of the trust, is definite and certain." Williams vs. Worthington, supra. There is no uncertainty in that part of the clause which respects the completion of the buildings or the construction of a new building, Crisp vs. Crisp, 65 Md. 422; and if there be any vagueness in regard to the subject of the alleged trust, it must be in the request or direction that the income "shall be devoted *mainly* to the care of the indigent insane." Here is an apparent uncertainty in the subject. What does *mainly* devoted mean? Does it mean the greater part of the income? If so, does it mean a fraction more than a moiety, or a fraction less than the whole? Clearly, the *quantum* of the subject dealt with by these precatory words is unascertained and indefinite. And this circumstance is a reason for holding, in view of all the other terms of the will, that no trust was intended.

Upon the entire will, in effect the testator has said to the Sheppard Asylum: I give you this property upon a single condition and bargain, which is, that you insert my name in your corporate title. When you have done that, the property is yours absolutely. But, though it is yours absolutely, by your acceptance of my condition, still I wish you would do a particular thing with *part* of the *income*. But this "wish and will" clause relating to the income is not made a condition, that is, does not embody a condition—upon compliance with which your absolute ownership of the *corpus* of the property is in any way to depend; for I have annexed but *one* condition in respect to that, and this "wish and will" clause does not contain that condition.

It should not be forgotten that words of recommendation and other words precatory in their nature, imply a discretion as contra-distinguished from peremptory orders, and therefore, ought to be so construed, "unless a different sense is irresistibly forced upon them by the context." Williams vs. Worthington, 49 Md. 585.

If we were disposed to rest the decision of this case upon mere precedent—that is, upon the construction placed on some parallel provision of another will—instead of grounding it upon principles applicable alike to all wills, we would rely on the case of Negro Chase vs. Plummer, supra. The will there interpreted contained an absolute bequest to the testator's sister, and there were superadded the following precatory words respecting certain slaves, part of the property absolutely bequeathed: "It is my *wish and desire* in case my sister Minny die without issue, that she

shall will and devise all my negroes to be free, or manumit them in any other way she may think proper; this request I hope she will comply with in time, *so as to carry my wish into effect.*" Afterwards the legatee died intestate without having manumitted the slaves; and it was contended by the slaves that they were entitled to their freedom, because the precatory words raised a trust in their favor. But this court, speaking by the late Judge Tuck, said: "In the will before us, the language is as plain as in any of the cases to be found in the books—on this point there is no difficulty—yet, looking to the entire instrument, the property, the nature of the supposed trust, and requirements of our laws in reference to manumission, we have come to the conclusion that such relief (that sought by the slaves) cannot be granted." Notwithstanding the strong expressions just quoted from the will, that it was the testator's "wish and desire" that the legatee "*shall*" liberate the bequeathed slaves, it was held that these words did not convert the absolute gift of the slaves into a gift of them upon a trust, because such a construction would have created a repugnancy, in the same clause, between the absolute gift and a gift upon a trust, and because the trust set up if declared, would have been against the rules of law. It would have been contrary to the rules of law because the mode then provided by statute for the manumission of slaves was different from the one contemplated by the will. In spite of the strong precatory words no trust was allowed to be raised by them for the reasons just stated, but not because the words themselves would not under other conditions have been sufficient to create a trust. The case pointedly illustrates the application of the principles we have been discussing; and it unequivocally holds that precatory words of little if of any less apparently imperative character than those used by Mr. Pratt must yield when the whole instrument, the obvious intention of the testator and the nature of the supposed trust indicate that it was not the purpose of the testator to create a trust at all.

Without going into any further discussion, we conclude by saying that, in our opinion, judging from the face of the entire will, it was not the intention of Mr. Pratt to create an imperative trust when he used the precatory words contained in the residuary clause; and that, therefore the Sheppard Asylum took the property covered by the residuary clause without that property being impressed with any trust whatever. This being so, of course no question as to a perpetuity can possibly arise, and it follows, necessarily, so far as the appellants in this case are concerned, that there is no error in the decree from which they have appealed. That decree denied them the right which they set up to the property disposed of by the residuary clause, and being right in this particular it will be affirmed.

—Decree affirmed with costs in this court, to be paid out of the funds.

COURT OF APPEALS OF MARYLAND.

ELLEN J. O. PHINNEY, ET AL.

vs.

THE TRUSTEES OF THE SHEPPARD AND ENOCH PRATT HOSPITAL, ET AL.

(October Term, 1898.—Filed Dec. 21, 1898.)

Two appeals in one record from the Circuit Court of Baltimore City.

Abner McKinley and *E. J. D. Cross* for appellants.

William Pinkney Whyte, *Willis & Homer* and *Barton & Wilmer* for appellees.

Argued before McSherry, C. J., Bryan, Briscoe, Pearce, Page, Boyd and Fowler, JJ.

A preamble contains no legislation, and whatever its statements may be, they are no part of the subject enacted into law. There is no violation of the Federal Constitution for the legislature, with the concurrence of the corporation, to change or modify the charter of the corporation, and no third party can invoke the provision of the Federal Constitution against the impairment of contracts.

McSherry, C. J.—Having decided in the preceding case that no trust was, or was intended to be, created by the residuary clause of Mr. Pratt's will, it remains now for us to consider the contention of the alternative residuary legatees and devisees. This contention is that the Act of Assembly of 1898, Chapter 17, changing the name of the Sheppard Asylum to the Sheppard and Enoch Pratt Hospital, is unconstitutional and void; that consequently the condition upon the happening of which the property disposed of by the residuary clause was to vest in the Sheppard Asylum did not come to pass, and that therefore the alternative legacy and devise in the same clause took effect and the estate devolved upon these legatees and devisees, the appellants in this case. It is insisted that this statute is invalid because, *first*, it violates Section 29 of Article 3 of the Constitution of Maryland; and because, *secondly*, it conflicts with Section 10 of Article 1 of the Constitution of the United States.

The title of the Act of 1898, Ch. 17 is in these words: "An Act to change the name of The Trustees of the Sheppard Asylum, incorporated by the General Assembly of Maryland by the Act of 1853, Ch. 274, as amended by the Act of 1886, Ch. 9." There are two enacting sections preceded by a brief preamble. The preamble recites the original incorporation. It then alludes to the great interest which Mr. Pratt manifested in the management of the institution, and declares that the purpose of the statute is to carry out the suggestion contained in his will with reference to a change of the name of the body corporate. Then

follows section one containing the effective, affirmative enactment changing the original name of "The Trustees of the Sheppard Asylum" to "The Trustees of the Sheppard and Enoch Pratt Hospital," and prescribing that the corporation by the new name shall hold all the property, enjoy all the rights and possess all the powers and functions which were possessed by or conferred upon it under its former name," and shall hold in like manner all property and estate which it shall acquire by will or otherwise under said change of title hereby made." Then comes section two, providing that the act shall take effect from the date of its passage.

The provision of the State Constitution which is relied on to defeat the enactment is in these words: "And every law enacted by the General Assembly shall embrace but one subject, and that shall be described in its title." This section has been before this court a great number of times. It has been invariably held to mean that the title shall sufficiently describe the subject of the legislation, but that it need not give an abstract of the contents of the Act. The primary object of the provision undoubtedly is to exclude all foreign, irrelevant or discordant matter from a statute and to confine the statute to the single subject disclosed in the title. Davis vs. The State, 7 Md. 151; Mayor, &c., vs. Reitz, 50 Md. 579; State vs. Norris, 70 Md. 91; Trustees, &c., vs. Manning, 72 Md. 133; Scarf vs. Tasker, 73 Md. 378. A casual glance at the body of the Act under consideration will reveal its absolute and exact accordance with the title.

It is true there are certain recitals in the preamble, but strictly speaking the preamble is no part of the statute, though it may be resorted to in explanation of the enacting clauses whenever the meaning of the latter is doubtful. Lucas, et al. vs. McBlair, et al., 12 G. & J. 17-18. But a preamble contains no legislation, and therefore no matter what its statements may be they are not parts of the subject enacted into law. The enacting clause follows but does not precede the preamble, and whilst the latter may disclose the reasons that induced the legislature to adopt the Act, it obviously forms no part of that which *is* enacted. Even if it should be out of harmony with the body of the Act, forming, as it does, no part of the statute, the statute cannot be said to contain foreign and discordant matter not disclosed in the title. But we do not regard the recitals, even if they formed part of the statute, as at variance with the subject named in the title, because at most, as already remarked, they simply state the reasons that influenced the action of the legislature.

Nor are the clauses which are contained in the body of the statute and which declare that the corporation by the new name shall hold all the property and enjoy all the rights and possess all the powers which were possessed by or conferred upon it under its original name, such foreign and discordant matter as to expose the act to the criticism that it contains provisions not disclosed in its title. These clauses add nothing to the powers formerly possessed and are merely declaratory of a result that would have followed a change in the name though they had been wholly

omitted from the act; because under its new name all of the original rights, privileges and liabilities would have remained unaffected by the change of its name. 7 Am. & Eng. Ency. (2d Ed.) 686. The identity of the corporation was not altered—it continued to be, under the new name, precisely the same corporate body that it formerly was, with exactly the same and no greater powers. The declaration that the corporation "shall hold in like manner all property and estate which it shall acquire by will or otherwise under said change of title hereby made" did not enlarge its authority to take or to hold property.

By its original charter it was made "able and capable in law to acquire property, real, personal and mixed, by gift, devise or purchase, and to hold, sell and dispose of the same," without limitation as to amount or value. None of the clauses following the actual change of the name in the first section of the Act, added anything that would not have resulted by operation of law from the naked change of the corporate name; and so the section cannot be said to contain extraneous matter because these clauses are embodied in it.

The second objection is that the act is repugnant to the Federal Constitution. When the original charter of the Sheppard Asylum—the *Act of 1853, Ch. 274* was granted, the Constitution of Maryland adopted in eighteen hundred and fifty-one was in force. By *Section 47 of Article 3* of that Constitution it was provided that "corporations may be formed under general laws, but shall not be created by special act, except for municipal purposes, and in cases where, in the judgment of the legislature, the object of the corporation cannot be attained under general laws. *All laws and special acts pursuant to this section may be altered from time to time or repealed.*" This provision was intended to be, and so far as language could make it so was, a clear and explicit limitation upon the power of the General Assembly to pass thereafter any act of incorporation not subject to repeal or amendment by the legislature. Upon the adoption of that constitution, every charter thereafter granted was subject to the paramount provisions of the organic law, which was binding on the legislature and the corporation alike.

The right of the State to repeal or alter a charter was an express condition upon which the grant was made in every instance after the Constitution of 1851 became effective, and an acceptance of the grant was an unequivocal, as it was irrevocable, acceptance of that condition. In this particular charter by the ninth section it is expressly declared that "the General Assembly may at any time alter or amend this Act." This right to alter or amend embodied in the Constitution and written in the charter, became a term or stipulation in the contract to which the State and the incorporators were the only parties. The right of the State under these circumstances to change the charter of a body corporate has been distinctly and finally settled by this court, in State vs. N. C. Ry. Co., 44 Md. 164; Am. Coal Co. vs. Con. Coal Co., 46 Md. 22; Appeal Tax Court vs. N. C. Ry. Co., 50 Md. 419; Jockson vs. Walsh, 75 Md. 304; and by the Supreme Court of the United States, in Shields vs.

Ohio, 95 U. S. 324; and Sinking Fund Cases, 99 U. S. 720. The State having not only under the organic law, but under the explicit terms of the contract contained in the charter, the unqualified authority to alter or amend the original act of incorporation, passed the *Act of 1898, Ch. 17*, simply changing the name of the corporation, and this act was assented to and accepted by the Trustees of the Sheppard Asylum. Even if there had been no power reserved to make such an amendment, still, if made by the State and accepted by the corporation it would have been perfectly valid. The Regents, &c., vs. Williams, 9 G. & J. 416; Jackson vs. Walsh, supra, 316.

But laying all this aside, it is obvious and certain that if the parties to a contract—the State and the body corporate in this instance—see fit to modify or change that contract, and accordingly do change it by a mutual concurrence, as was done by the passage of the Act of 1898, Ch. 17, by the State, and the acceptance of that Act by the body corporate, not only is there no impairment of the obligation of the original contract; but even if there were, or could be under such conditions, no one other than the *parties* to that contract could invoke the provisions of the Federal Constitution to uphold it. And this the Supreme Court has recently declared in Williams vs. Eggleston, 170 U. S. 309. Speaking for the court Mr. Justice Brewer said: "The parties to a contract are the ones to complain of a breach, and if they are satisfied with the disposition which has been made of it and of all claims under it, a third party has no right to insist that it has been broken." Clearly, therefore, these alternative residuary legatees and devisees, who are *not* parties to the contract contained in the charter, and who were only to take under the will in the event that the legislature did *not* change the name of the corporation, have no standing to insist that, though the legislature *did* change the name, it had no power to do what it did do and that they are, consequently, entitled to the property.

We hold, then, that the *Act of 1898, Ch. 17*, is not invalid for any of the reasons assigned, and as the other questions involved have been disposed of in the preceding case, the decree in so far as it affects these appellants will be affirmed.

—Decree affirmed with costs in this court, to be paid out of the fund.

Notes and Comment

Paretic Dementia Among Railway Employees.—Dr. J. G. Rogers, of the Northern Indiana Hospital at Logansport, presented in a paper before the American Medico-Psychological Association some interesting statistics respecting the development of paretic dementia among railway employees. These statistics were the result of systematic inquiries of about seventy representative institutions for the insane in the United States and Canada, covering a period of ten years ending December 31st, 1898. The total number of paretics reported was 5947; of paretic railway employees, 274 (4.6 per cent.), and of insane railway employees of all sorts, not paretic, 572 (9.6 per cent.). The comparative statistics showed that hospitals in the Southern States cared for a relatively small number of paretics of all vocations, and that the average above-mentioned (4.6 per cent.) was considerably exceeded in Ontario, Pennsylvania, Michigan, Iowa, Minnesota, Ohio, Illinois, and Northern Indiana. In New York the average obtained. In New England it fell to 3 per cent., and elsewhere the percentage was still less.

Of the 274 railway paretics, 93 (34 per cent.) were engineers; 39 (14.2 per cent.) were conductors, and 141 were firemen, mail agents, baggage masters, express agents, brakemen and motormen, in the order of their frequency. Of the total number of insane railway men, 846, 32.3 per cent. (274) were paretics. Considering the insane generally, classified by vocations, in no other class will so large a precentage of paretics be found. In the Northern Indiana Hospital for the past ten years there have been 100 male paretics; nine of these were railway employees, and every insane railway employee was clearly a paretic.

His conclusion is that the mental strain and physical jar incident to railway work are in a notable degree coadjutors in the causation of paretic dementia. He does not question the great importance of old syphilis, but considers that other influences assist decidedly in the development of the disorder.

Dr. Joseph Goodwin Rogers, the newly elected President of the American Medico-Psychological Association, was born in Madison, Indiana, in 1841, of parentage from Kentucky and Connecticut. His father was a physician of local note. He was forced to leave the high school of his town in his 13th year, on account of spinal caries, resulting from a blow given in sport by a schoolmate, which, according to the fashion of the day, confined him to his bed for five years. During this time, with or without tutors, he pursued the studies of the usual college curriculum, including the French and German languages and English literature. When able to get out in the world again he devoted sometime to travel and then spent a year in the study of law, to please his father; at twenty, however, he became a student of medicine to please himself, and was graduated in Bellevue Hospital Medical College in 1864. Soon after, he was appointed assistant surgeon, U. S. Army, and served in this capacity until the close of the war. The years 1865-66 he spent in Europe, mostly in the clinics of Paris, especially those of Trousseau, Nelaton and Desmares, with occasional tours into Switzerland, Italy, Germany, Scotland, England and Ireland. Returning he entered general practice at Madison. In 1874-76 he filled the chair of Therapeutics in the Medical College of Indiana, at Indianapolis, but afterwards resigned because of interruption to practice at Madison. The summer of 1875 he spent in Europe. For several years about this period he assisted the late Dr. Theophilus Parvin, then in Indianapolis, in the conduct of the *American Practitioner*. In 1879 he, unexpectedly, was appointed Superintendent of the Indiana Hospital for Insane, at Indianapolis. During his incumbency of four years, the department for women was opened, making this institution one of the largest in the country. From 1883 to 1890 he was medical engineer to the commission empowered to build the new hospitals at Logansport, Richmond and Evansville. In 1888 he opened the former, as medical superintendent, and within the two following years, the others, with former assistants in charge.

Dr. Rogers has always maintained an active interest in the insane of his State and has done what he could to study and publish their conditions, to secure State-care for them and to protect them from the vicissitudes of political interference and entertains

a warrantable pride in the present standing of his State in the care of her insane. He has been an active member of the American Medico-Psychological Association for twenty years.

A Deplorable Mistake.—We have been strongly urged to lay before our readers, after first obtaining, of course, the permission of the enterprising New York newspaper, which has copyrighted the article, a most remarkable contribution to medical science, made in a most remarkable manner, with all the sensationalism of glaring head lines, striking illustrations and portraits. We refer to an article in the *New York Herald* of June 11th, 1899, the material for which, it is intimated, was furnished by the gentlemen who conduct the Pathological Institute of the State Hospitals of New York. Time was when the publication of medical cases and alleged medical discoveries in newspapers by members of the profession was considered improper and undignified, but some of our brethren in New York, not alone those connected with the Pathological Institute, seem to have regarded the usual channels for scientific publication, with their lack of sensational head lines and striking illustrations, too antiquated.

The article in the *New York Herald* is not by any means the first instance of the publication in the daily papers of alleged scientific discoveries.

We have before us not only the *Herald* of June 11th, with the startling announcement that new methods may lead to "an absolute reversal in the treatment of the insane," that asylums may be "totally abandoned" but also a copy of another metropolitan journal announcing an "American scientist's most amazing discovery, the germ of insanity." The daily papers have not heretofore been considered exactly the medium for the transmission to the profession of great scientific truths or discoveries; and moreover the New York State Hospitals have for some years maintained publications admirably suited to such purposes.

We are happy to record the promptness with which the physician who was alleged to have furnished the *New York Journal* the data for its sensational article on the "germ of insanity" denied in the *State Hospitals Bulletin* "any responsibility" for the publication. Here was a most excellent example for the officers of the Pathological Institute to follow.

In the *Washington Post* of March 7th, 1897, appears another contribution giving some remarkable experiments "in tracing the causes of insanity" made in the New York State Pathological Institute. As all of these papers came into the hands of the writer by accident, it is presumed that he has lost the opportunity of reading much more of the same tenor, possibly from similar sources, because of the fact that he is not a constant reader of the metropolitan Sunday newspapers.

We have watched with great interest the formation of the Institute of Pathology for the New York State Hospitals. We have read and re-read the contributions of its learned director in the *State Hospitals Bulletin* and its successor the *Archives of Neurology and Psycho-Pathology*, and while, as we have stated in reviews of various reports of the New York State Commission in Lunacy, we have not always agreed with everything that has been put forth from the Institute of Pathology we have expected, from the character of its director and staff and from the unlimited opportunities before them, much of lasting value. We have felt some doubts as to the complete success of an institute carried on so far removed from clinical observations of the insane, which, notwithstanding what has been said by the able director, must, we believe, be necessarily intimately associated with scientific study of any value concerning the insane. We have welcomed what seemed, however, to promise a decided step in advance in scientific methods in study and have looked forward with pleasurable anticipations to being able to lay before our readers some of the results of these investigations. Alas! however, we were doomed to disappointment. The daily press appears to have been preferred. At least, although over a month has passed since the publication of the article, and the gentlemen involved have been invited through the pages of one of our medical contemporaries to "purge themselves of this contempt of professional opinion," no attempt has been made, to our knowledge, by those who are involved, to disclaim not only the publication but the views contained therein. The gentlemen connected with the institute cannot, we believe, afford to rest under the imputation that they are responsible or even that they have been as the *Philadelphia Medical Journal* kindly puts it "hood-winked by reporters." The numerous quotation marks, the general phraseology of the article,

the intimate acquaintance which the newspaper publication shows with a case which has, as far as our information goes, only been referred to in a brief paragraph or two, indicate, we fear, that the neswpaper article was obtained by the direct connivance, if not through the assistance of some one or more of the gentlemen connected with the Pathological Institute.

We regret very much that the gentlemen connected with the institute before permitting themselves to be made the victims of so-called newspaper enterprise did not again read the excellent words put forth by the director of the institute in the first number of the *Archives of Neurology and Psycho-Pathology* concerning the haste which was sometimes made in America in attempting to drive science. "No sooner," he says on page 261, "is a scientific institution inaugurated than results are immediately demanded; the task of conforming to these demands has been particularly hard in this institute for it had no precedent to follow; it had to plan out all of the work on an entirely new basis. Haste is the bane of scientific research. . . An institute devoted to the science of psychiatry is like an organism, it must grow and develop, it cannot become great by the irrational demand (*sic*) of the 'workers' in medicine to make hasty 'work.'" In this unfortunate instance the demand for "results" seems to have been made by sensational newspapers; the "workers" in medicine were only too willing that the observers at the institute should make haste as slowly as the demands of the various problems which confronted them necessitated. The profession did not desire, nor did it expect, from the institute hasty generalizations based upon but one or two sensational cases, but hoped after studying the programme promulgated by the institute, that in time some results might be announced which would be of value to the profession and which would advance the cause of psychiatry. It is to be hoped that the unfortunate mistake which has been made in yielding to a demand, made not by the profession, let it be remembered, for hasty results, will not entail such a disorganization in the institute and its methods as shall disappoint the natural expectations of the profession for the future.

THE FIFTY-FIFTH MEETING OF THE AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.—The American Medico-Psycho-

logical Association attained its fifty-fifth year at its annual meeting in New York, in May. It was a notable meeting in its exhibition of the results that have been gained in ten years through measures adopted for the purpose of promoting the advancement of the Association in its work.

When the meeting was held at Newport ten years ago, the number of members recorded was 153, there being few others than those who were, or had been, superintendents of institutions for the insane. In accordance with action then taken the names of assistant physicians of five years standing who wished to become members were thereafter entered on the records, and in consequence the membership was increased to 266 in 1890. This put in effect the purpose of stimulating the professional interest of our younger colleagues in the work of the Association; at the same time the payment of a regular, annual assessment was required of all its members instead of placing the burden of its support upon those who attended the meetings. The New York meeting began its sessions with 321 members, and at its close the number approximated 400.

At the two Washington meetings, in 1891 and 1892, was accomplished the transformation of the Association to its new organization under its present name. The object was to enlarge the new purposes already conceived for the advancement of the Association, and, as was stated in the presentation of the new constitution, "to preserve intact, so far as possible, its traditions, its membership, seeking to give stability to its future work, and to put it in a position to hold property and to do other things common to the work of such an Association." The plan included the granting of privileged membership to assistant physicians, and the admission of physicians interested in the study of insanity other than those connected with institutions.

The evolutionary forces set in operation by the new conditions under which the Association began its second half-century made their mark at the semi-centennial meeting at Philadelphia in 1894, which was a memorable epoch in the life of the organization. The publication of an annual volume of "Transactions" was then begun, in the first of which the events of that meeting are recorded. This was the first product of the policy of putting money in the treasury to "do things" that are good for the

Association to do. We now see the striking result of the action taken at Philadelphia through which possession was acquired, that year, of the AMERICAN JOURNAL OF INSANITY; it was copyrighted in the name of the Association, which being then incorporated thus gained the right to hold property in pursuance of one of the purposes of its reorganization. It was but a natural sequence that the new spirit animating the work of the Association should soon show itself in the improved quality and appearance of the JOURNAL with the debt of its purchase paid. At the New York meeting the treasurer was able to report that the JOURNAL is now self-supporting; and there was so substantial a balance of funds in the treasury that the Association did not hesitate to authorize the preparation of "a history of psychiatry in America and of the contributions to it by the work of its own members, and to vote to employ an editor to make the publication a complete and worthy one" to fittingly record, in the closing year of the century, the progress it has made. These are some of the tangible results of its new business methods upon which the Association is to be congratulated.

We cannot omit to mention the great variety of the papers presented at the meeting and their valuable scientific character. Some of them appear in the present number of the JOURNAL OF INSANITY, and others will appear during the year; and all ultimately in the Transactions. In excellence, number and variety they exceeded the papers of any previous meeting. It was a matter of regret at times that their number precluded that free discussion which has proven so profitable on other occasions.

The courtesies which were extended by the managers of the Manhattan State Hospital, of the New York Hospital, and the Morris Plains Hospital, added much to the enjoyment of all the members. The boat-ride along the water-front of the city, terminating in a visit to Ward's Island, with an inspection of the institutions and a charming tea given at the hospitable residence of Dr. A. E. Macdonald, contributed much to the social life of the meeting. In every aspect the fifty-fifth meeting was most successful.

TENTH ANNIVERSARY OF CLARK UNIVERSITY.—Through the kindness of Dr. Adolf Meyer of the Worcester Insane Hospital

we are able to place before our readers the annexed brief account of the lectures of S. Ramon y Cajal, Angelo Mosso and August Forel, given in Worcester at the tenth anniversary of the opening of Clark University.

One of the most interesting and brilliant celebrations has just come to an end. Owing to the genius of President G. Stanley Hall, the celebration of the decennial of Clark University was made the occasion of bringing to this country Professor Boltzmann, physicist in Vienna, Professor Picard, mathematician at the University of Paris, Professor Mosso, the physiologist of Turin, Professor Cajal, histologist and general pathologist of the University of Madrid, and Professor Forel, formerly director of the psychiatric clinic at Zurich. These lecturers and the gathering of guests from all the universities of this country marked the celebration with a success which surpassed our expectations.

The two departments of Clark University, the mathematical-physical and the psychological-biological have conquered such a position that it is difficult to realize that they have just closed their tenth year of existence. The place of the celebration was fully in keeping with the breadth and vigor shown all this time by President Hall and his associates. Since the lectures of the famous guests and the addresses of Dr. Hall and others will be published soon *in extenso*, only a short account will be given here of the men and of the topics which bear some relation to the field of psychopathology.

Professor Angelo Mosso, whose brilliant books on fatigue and on fear represent the finest type of popular science, delivered two lectures on the relations of the motor apparatus and psychic life, the first chiefly referring to the necessity of motor development as a foundation for the intellectual life, the second dealing with emotions and their organic foundations, illustrated especially by the interesting phenomena observed in the activity of the bladder in a recent research on that organ. To abstract these brilliant and suggestive addresses would be unfair to the reader. They will be published in English.

The contributions of Professor S. R. y Cajal were of quite a different stamp. Two lectures were devoted to a minute description of his recent studies of the visual cortex of man, and a third dealt with the motor and other regions of the cortex. The very remarkable accuracy of description and the sober, critical presentation, free from hypothetical flights displayed principles of work which unfortunately are abandoned by too many to-day: it was not an attempt to prove a preconceived hypothesis, but primarily work for the accumulation of data; the result was none the less gratifying since Cajal was able to demonstrate new facts of great importance, especially concerning the mode of termination of the afferent fibers. The layer of small granules beneath the layer of medium pyramids appears to be the principal station of termination of incoming fibers. Another point of great interest is a new observation on the peculiar cells of the molecular or plexiform layer which have received Cajal's name. Cajal

demonstrated specimens from the new-born with a great number of vertical side-branches reaching the surface. These branches are far less numerous a few weeks later and have probably been resorbed. It would appear that the number of processes is primarily greater than is absolutely necessary and that a secondary resorption or weeding out reduces the number. If this could be demonstrated on other cell-types with equal precision, Cajal would have added data for a very interesting genetic law.

Cajal's views which are substantially those of Forel and His, as to the neurone theory so-called, appear not to be shaken by the publications of Apáthy and his followers. Whatever the merit of the latter may be, the careful work of Cajal gives ample evidence of rather hasty conclusions on the part of his opponents. Much has been said of the artifacts produced by the Golgi method; but the critics ought to remember that a man of Cajal's judgment is not so apt to be misled as a beginner, and that even the famous fibril-stains of the day will have to pass the test of more general use before the last word is to be spoken. Cajal is unable to accept the views expressed by Nissl concerning an intercellular meshwork of fibrils independent from nerve-cells and a chief bearer of nervous functions. On the other hand, Cajal is more guarded concerning the theories of nervous function than formerly; he expressed considerable scepticism concerning the retraction theory of Duval, and never mentioned his own theory concerning the neuroglia, but rather insisted on the absolute necessity of withholding opinions until more conclusive facts are available. That patient and steady work will in the future as in the past lead to more valuable results than a mere elaboration of ideas, is strongly proved by the entire history of Cajal's career.

Forel's contributions came from two of the many fields in which this marvelously many-sided and active scholar has established his name, the life of ants and hypnotism. The perusal of both papers will certainly repay the reader; it is impossible to give a concise summary. In the discussion of hypnotism, Professor Forel gave a summary of the views and facts which are contained in the third edition of his remarkably lucid and critical work on this subject.[1]

It would have been very interesting for the alienists of this country to hear his views concerning the anti-alcoholic movement. It is to be hoped, before he leaves the country he will give expression to his long and broad experience in this great social problem.

The decennial has brought us a mass of suggestions, and those who had the good fortune to see the men thus brought to America will feel forever under obligations to President Hall. Those who were not able to be present will not fail to find much of the stimulating spirit in the volume to be published in memory of the great event.

RETIREMENT OF MR. GOODWIN BROWN.—The recent appointment of Mr. William C. Osborn as the legal member of the New

[1] Der Hypnotismus und seine Handhabung, 3 Aufl. Stuttgart, 1895.

York State Commission in Lunacy in place of Mr. Goodwin Brown, whose term of service had expired, changes the entire *personnel* of the Commission as first constituted, and at the time the State Care Act was passed and set in operation. Of the original members, Dr. Carlos F. MacDonald retired in 1896, Mr. H. A. Reeves in 1897 and Mr. Goodwin Brown during the present year after ten years of service. The retirement of the last member of the original Commission renders it peculiarly appropriate to print the resolution which was adopted at a special session of the Commission in Lunacy, May 31, 1899, as giving a summary of its work:

"*Whereas*, after a service of ten years as a Commissioner in Lunacy of the State of New York, the Hon. Goodwin Brown has retired from the Commission, and it is appropriate that the existing Commission record its esteem of his work and administration; and *whereas*,

"The present admirable design and system of the official work of this department and of the State Hospital system is in large part due to the untiring efforts of Mr. Brown while a Commissioner, and is considered by those best fitted to judge of its worth, worthy of the highest praise; and *whereas*,

"He was a chief factor in creating that memorable chapter in the history of lunacy in New York, known as the 'State-Care Act'; and *whereas*,

"Mr. Brown's services to the State in this regard present an illustration of the best political economics and offer a brilliant example of humanitarianism; having been always directed to the interests of the State, and never having overlooked the safety and welfare of the insane, for which the State-Care Act was created; *now therefore*,

"*RESOLVED*, That in the opinion of the Commission in Lunacy on the retirement of Mr. Brown from the Commission, the State loses a valuable and conscientious servant; the insane, a persistent, benevolent and able advocate, and his former colleagues, a friend valued for his manhood, loyalty and the absolute courage of his convictions."

Obituary.

DR. W. W. GODDING.

[In place of a formal obituary, we publish extracts from a tribute presented at a special memorial meeting of the Medical Society of the District of Columbia, June 7th, 1899, by a member of the medical staff of the Government Hospital for the Insane.—EDITOR.]

We meet to-night to pay a tribute of respect to Doctor William Whitney Godding, one of the most widely-known, and most beloved physicians in the District of Columbia.

It has been my pleasure to know Doctor Godding, intimately, for more than a dozen years. I have seen him under all circumstances; have known him in his official capacity, as Superintendent of the Government Hospital for the Insane; in his domestic life, as husband and father; in his relations with the world at large; and have known him as a friend, meeting on an equal footing, and, to some degree, perhaps, as far as any other man, knowing him, deep down in his heart, beyond where public gaze has ever penetrated. Of him I can testify nothing but good, and I can truly say that to know Doctor Godding intimately, and to possess his friendship, was, indeed, a great privilege.

Now that he has gone from us, and I am able to look at his life as a whole, as I have known him and learned of him from friends and acquaintances outside his own family and relatives, I see that it was a life of greatness, based upon firm principles of honor and honesty, and may well be taken as an example of highest manhood.

Doctor Godding was of English descent, and was born in the town of Winchendon, Massachusetts, May 5, 1831. A month ago, when I chanced to be there, I saw the house in which he began his earthly career. Driving out from the village, a mile, to what is known as the "middle of the town," I saw on the side

of a hill, surrounded by green fields, a group of some half-dozen houses, a country church, and an old district school. As I approached the spot, I thought it one of the most beautiful bits of New England country I had seen. The houses were scattered on both sides of the road, all painted white, with green blinds, and, although old in years, yet so well preserved, and freshly painted, that, but for the style of architecture and general quaintness of them all, they might have been built a dozen years ago. It was in one of this small group of houses, really in the country, but considered a part of the busy manufacturing town of Winchendon, that William Whitney Godding was born, sixty-eight years ago. I stopped before it, to see under what environment the world first appeared to our friend, whose body we had only the day before borne to its last resting place. There was an atmosphere of purity and a touch of nature about the place that pleased me. The old-fashioned house, with curious gables and broad piazzas, stood back from the road, with a well-kept old-time garden about it, in which the spring blossoms were just beginning to bloom along the garden paths; fruit trees of apple and pear, were scattered through the garden, while the house itself was surrounded by tall maples.

Across the little valley was the churchyard in which the doctor's ancestors for three or four generations are buried. The village church, with high old-fashioned spire, stood on the opposite side of the road a few hundred yards away. Looking off to the north was the town of Winchendon with the surrounding hills, and beyond, Monadnock, a mountain peak in New Hampshire, whose head towers above everything else within the range of vision. The place suited the man, who as a child knew it as home, and well may it be proud of the son who went forth from its roof to perform his part in the drama of life.

Doctor Godding's father, Alvah Godding, was a country physician, and from him, undoubtedly, Doctor Godding inherited many of the best traits of his character. The name of Alvah Godding to-day, in that old town, represents everything that is dignified and honorable. I was told by some of the old inhabitants of the place that he was a man of broad culture, great tenderness of heart, and large benevolence. He had great sympathy for those of his patients whose pecuniary circumstances placed

them in embarrassing positions, and who feared to apply for medical attendance, on account of an unpaid bill, but the good doctor was ever as ready to minister to these, and to the poorest of his patients, as he was to what were considered the "best families," where he might, reasonably, expect his pay to be more certain.

No day was too cold and bleak, no night too stormy and dark, for this God-fearing man to go forth to alleviate suffering, and like many other men of his generation in our profession, he finally, at the age of seventy-eight years, gave his life to answer a sick call. Strolling through the cemetery, I chanced to come upon his grave, on the headstone of which is inscribed "He who loseth his life, shall find it."

Doctor Godding's mother was Mary Whitney, a member of an English family of that name, who came from Whitney on the Wye, in 1635, and settled at Watertown, Massachusetts. A woman of intellectual attainments, great energy, and marked executive ability, she was an earnest worker in the church, and an old-fashioned housekeeper, who prided herself upon the excellence of her table and the perfect order of her household. She would entertain a whole church conference if need be, attend all church meetings, and keep her household running up to the highest degree of perfection. Of Doctor Godding's mother an old minister once said that "half a dozen men with her firm convictions and moral courage would revolutionize a town." She believed in Christ as easily as she trusted her mother, and her soul drank in divine truths as though it were her natural nutriment. Intelligent and kind-hearted, she was a power for good in the church and in the community in which she lived.

From both his parents Doctor Godding inherited his strong characteristics, and in them, we find the keynote to the development in him of so much that was broad and lovable. I am told that he was early recognized as a superior boy. He manifested marked mental development early in life, and with the best of home influences, though an only child, he was easily led into habits of industry and conscientious regard for duty. His early education was begun in the district school, above referred to, which he entered at the age of five, and where he remained until his tenth year. Having gotten to an age when he could safely

be sent further from home, his father had him admitted to the academy in the village of Winchendon, a mile away, where he remained until his sixteenth year. Having finished the course here he went to Brown University, at Providence, Rhode Island, but finding that his preparatory education in certain branches had been neglected, he remained only six months, when he left to go to Phillips' Academy, a preparatory school, at Andover, Massachusetts. He remained in this school two years, preparing himself for college. In the year 1850 he entered the Freshmen class at Dartmouth College. He soon became popular with his teachers and classmates, among the latter of whom there are, to-day, some of our most prominent men in science and politics.

Graduating at Dartmouth in 1854, at the age of twenty-three years, Doctor Godding began reading medicine in his father's office and, a few months later, attended his first course of lectures at the College of Physicians and Surgeons, in New York City. For some reason he remained there only one year, and a year later, took his degree of M. D. at the Medical College at Castleton, Vermont.

After graduating he began the practice of medicine, with his father at Winchendon, where he remained for a period of eighteen months, at the expiration of which time he was offered a place as Assistant Physician in the State Hospital for the Insane at Concord, New Hampshire. Here began his life among the insane, June 1st, 1859, and to the close of his remarkable career he devoted all his time and energies, with the exception of a single year, to this great life-work.

Doctor Godding was married December 14th, 1860, to Miss Ellen Rowena Murdock, the daughter of Mr. Elisha Murdock, a manufacturer of wooden-ware, a leading business man of Winchendon and one of the most prominent social figures in that section of the State. After his marriage, Doctor Godding returned to the hospital at Concord, with his wife, and continued his work there for a period of two years longer. He resigned his place again to enter private practice, and went to Fitchburg, Massachusetts. At the expiration of a year he was again sought, for a place in a hospital for the insane. There was a vacancy in the staff at St. Elizabeth, and the Superintendent, Doctor Charles H.

Nichols, having heard of Doctor Godding, as a young man of some experience, peculiarly fitted for the work, offered him the place of Second Assistant Physician. He came to Washington in September, 1863, and began work in the institution, of which, fourteen years later, he was to be chosen Superintendent. During the years that he remained with Doctor Nichols, Doctor Godding proved himself to be a man of great energy and industry, and altogether painstaking in his work. He remained very closely at the hospital, seldom leaving it to go to the city or to find recreation outside, except to take long walks in the country, of which he was very fond. He learned the history of St. Elizabeth from the beginning, and knew every stone and stump within its boundaries. He was a great reader of books in the line of general medicine, and of his specialty, and also, of the best literature of the day. He made close study of cases of especial interest, and wrote minute histories of many of them. A modest man, in no way attempting to parade his works or his attainments before the world, or, even before those most closely related to him, yet, the reputation he earned during the seven years following, went out before him, and in April, 1870, he was appointed Superintendent of the State Hospital for the Insane at Taunton, Massachusetts. The work in that institution was pleasing to Doctor Godding. He was in his native State, which he always loved, and to which he was ever loyal. He loved its hills and valleys, its rocks and trees, its flowers and its brooks, and, although he remained only seven years, I think, in after life, he looked upon the years spent at Taunton as among the happiest of his whole life. The hospital was not large. He had the entire confidence of the public, the patients and their friends, and the loyal support, at all times, of the board of trustees. He improved and enlarged the institution, and, so far as possible, beautified it, and made it altogether up to the highest standard of that time.

In the year 1877, Doctor Godding returned to St. Elizabeth. The only superintendent the Government Hospital for the Insane had known, Doctor Nichols, resigned to accept the superintendency of the Bloomingdale Asylum in New York City. Upon his resignation, Doctor Nichols was consulted by the Board of Visitors and the Secretary of the Interior as to his successor, and he, knowing the good work that Doctor Godding was doing

in Massachusetts, recommended him for the place. Doctor Godding returned here September 23, 1877, and never again, until his death, severed his official connection with the institution.

He found the hospital consisting of three buildings for patients—a main building, with receding wings, and two detached lodges for colored insane; one for women, and the other for male patients, the entire number of patients being about seven hundred. The buildings were greatly overcrowded and the number of patients increasing rapidly. He proceeded to make plans for new buildings, and petitioned Congress for an appropriation for a building for working men. He named the sum required to make the necessary provision, and Congress generously cut the amount in two and gave him half, but, with it, he did what could be done to provide for the rapidly increasing number of patients. Each year found the wards of the hospital overcrowded, and each year the doctor sought Congressional aid for the erection of new buildings. In his official contact with members of Congressional committees, Doctor Godding made many friends, and was looked upon as a man who never asked for what was not necessary for the best interest of the institution—his endeavors to secure appropriations being generally successful. As rapidly as possible, he built new buildings, arranging them in groups for the better classification of patients. The grounds were improved and beautified, and additional land for farming purposes secured.

With the growing population of the District of Columbia, the increased number of men in our army and navy, and the ever-increasing number of inmates of the national homes for disabled volunteer soldiers, from all of which sources St. Elizabeth admits the insane, the construction of additional accommodations occupied a large part of Doctor Godding's time and energies, and the hospital, to-day, one of the largest in the United States, admirably suited in every way to its needs, stands as a handsome testimonial of his wisdom and unceasing efforts. He hoped to accomplish much more, in the development of the place, and had made plans for important work during the coming year, in the construction of cottages at the lower farm, "Godding Croft"; the completion of a new laundry; the extension of a lodge for colored male patients; the construction of a large sewer; and making fire-proof a number of wards in the main building. Thus,

in addition to the great and ever-increasing executive work in the management of so large an institution he devoted much time and labor to the construction and remodeling of buildings, the improvement of the farm and the individual care of patients under his charge, numbering at the time of his death, almost two thousand.

All these duties required long hours of labor, and, during all the years I knew Doctor Godding, he arose early and worked long into the night. He was ever busy, yet always patient, and ready to listen to anybody who sought an interview. His work did not interfere with his devoting a number of hours, of the twenty-four, to reading, and he kept in touch with all that was going on in the world. He had an intimate knowledge of most of the new books of literature, art and science. He was a familiar figure at all book stores, and well-known by book-dealers, from whom he was ever ready to make a purchase. He was interested in everything new, and was, essentially, a progressive man. He enjoyed a good novel, or a book on almost any branch of science, was remarkably well-versed in Biblical history, and could quote hundreds of passages from the Bible. He was a fair Latin and Greek scholar, and, until a few years ago, was often to be found reading some passage from the classics. Of poetry he was especially fond, and was himself a poet of no mean ability, some of his unpublished writings, which I have read, being, indeed, beautiful in sentiment and expression. His style of prose was decidedly poetic. His lectures on mental diseases, delivered before the medical students of Columbian College, which he left unpublished, would constitute a most satisfactory hand-book of mental diseases.

Of his published writings, not in book form, the following comprise, perhaps, the most important:

1. 'The Last Chapter in the Life of Guiteau': "Alienist and Neurologist," October, 1882.

2. 'In Memoriam Wilbur-Walker': published in the "Alienist and Neurologist," July, 1883.

3. 'Our Insane Neighbor; His Rights and Ours': "American Psychological Journal," 1883.

4. 'The Insane; Their Treatment, Commitment and Detention': "American Psychological Journal," 1884.

5. 'Progress in Provision for the Insane, 1844-1884': "American Journal of Insanity," October, 1884.

6. 'Rights of the Insane': "American Psychological Journal," April, 1884.

7. 'A Vindication of History': "Alienist and Neurologist," January, 1885.

8. 'The Recognition of Classes of the Insane, in Asylum Construction': "Alienist and Neurologist," July, 1885.

9. 'A Judicial Advance—The Daily Case': "American Journal of Insanity," October, 1888.

10. 'Insanity as a Defence for Crime': "American Journal of Insanity," January, 1888.

11. 'A Talk on Brains': "International Record," January, 1888.

12. 'Sketch of Charles H. Nichols': "American Journal of Insanity," 1889.

13. 'The Disposition to be made of Criminal Lunatics': published by International Medico-Legal Congress, 1889.

14. 'Aspects and Outlook of Insanity in America': "American Journal of Insanity," July, 1890.

15. 'Review of Francis Tiffany's Life of Dorothea Lynde Dix': "Alienist and Neurologist," January, 1892.

16. 'The State in the Care of the Insane': "American Journal of Insanity," January, 1890.

17. 'Development of the Present Hospital for the Insane': "American Journal of Insanity, July, 1894.

18. 'A New Departure in Medical Jurisprudence': "American Journal of Insanity," October, 1894.

19. 'Then and Now; being Pictures from the Past': "American Journal of Insanity," 1896.

20. 'In Memoriam—Joseph M. Toner': "National Medical Review," December, 1896.

In addition to his scientific cast of mind Doctor Godding had a great amount of real sentiment. Modest and almost diffident, he was a most lovable man, with a heart so big and warm that it embraced in its sympathies and kindness, everybody with whom

he came in contact. His gentleness was almost womanlike, and, with the art of never saying anything unkind or offensive to anyone, is it to be wondered that the number of his friends was limited only by the number of his acquaintances? To people in sorrow and trouble, he was ever ready to give assistance. As a counselor, he was far-seeing, and superior in judgment. As a friend, he was ever watchful and true. He had a keen sense of humor, a hearty laugh, and thoroughly enjoyed a good joke. Occupying the place he did for so many years, at the head of a hospital for the insane, he was often approached outside its walls, by people of curious types, with all sorts of theories, schemes and advice. These he would listen to with a patience seldom found in mortal man, and dismiss them in a way that made them feel that they were indeed wise, and their wisdom thoroughly appreciated. He treated all these people in a manner that at once won their entire confidence, and he seldom made an enemy among all the various types of people whom he met.

Doctor Godding's tenderness of heart extended to dumb brutes and animals of all kinds, and to them all, as to humanity in general, was he ever thoughtful and considerate. To the people of St. Elizabeth, and to the members of his medical staff, he was a kind father and a considerate ruler, and the sorrowful faces to be seen there, on that seventh of May, when the employees and many of the patients, filed into the room in which his body lay, to take a last look at the face of their beloved superintendent, bore witness to the warm place in their hearts that he had occupied.

Doctor Godding's domestic life was ideal, and I have seldom met a family so devoted and harmoniously united. The same charm of manner that characterized his relations with the general public applied with even greater force to his relations to his family. His politeness and gentleness to strangers never exceeded that at all times and under all circumstances paid to his wife and children, and his example as husband and father was perhaps as nearly ideal as one can imagine.

The many expressions of sorrow and sympathy, coupled with those of great personal loss, from many of the best people throughout the United States, since his death, testify how much he was beloved by all who knew him. He has gone to his re-

ward, and the world in which he lived is better for having known him.

> "If God so wills—I do not know
> And yet my heart would have it so—
> When dimming eyes, and silent lips
> Shall close these earthly comradeships,
> I pray that I may wake in bliss
> And find my mansion next to his."

JOHN CRAYKE SIMPSON.

St. Elizabeth, June 1, 1899.

WILLIAM A. GORTON, M. D.

Dr. William Arthur Gorton, physician and superintendent of the Butler Hospital for the Insane at Providence, R. I., died at the Boston City Hospital, May 1, 1899, after an illness of several months' duration. An operation for gall-stones, successful in itself, failed to save life owing to an ulcer of the duodenum, whose existence had not been suspected and which in any event must soon have proved fatal.

Dr. Gorton was born, June 21, 1854, in North Brookfield, Madison county, N. Y., where members of his family still live. He was the son of Tillinghast and Adaline M. Rice Gorton. On his father's side, he was descended from Samuel Gorton of Rhode Island, and his mother's family was prominent among the early settlers of Massachusetts. His maternal great-grandfather was Oliver Wright, who died in Sturbridge, Mass., in 1765. His early education was obtained in Brookfield and at Whitestown Seminary, New York, an institution now extinct but famous in its day for its excellent teaching and as a feeder to Hamilton College. After graduating from the Seminary in 1873, he entered the medical department of the University of the City of New York, at which institution he took his degree in 1876. Thereupon he entered Bellevue Hospital to remain on its house staff eighteen months. For about eight months he was engaged in practice in Cooperstown, N. Y., in association with Dr. L. H. Hills, now of Binghamton, N. Y. In June, 1878, he became assistant physician in the New York State Asylum for Insane Criminals at Auburn, N. Y. (now the Matteawan State Hospital

at Fishkill-on-the-Hudson). After a service of three and a half years he was appointed assistant physician at the Danvers Lunatic Hospital, succeeding, in 1886, to the superintendency when Dr. Goldsmith became superintendent of the Butler Hospital. On the death of Dr. Goldsmith, Dr. Gorton succeeded again to his former chief's position, assuming charge of the Butler Hospital in May, 1888. Dr. Gorton married, June 8, 1887, Miss Mary Elizabeth Langley, of Danvers, Mass., by whom he had four children, three of whom survive.

Dr. Gorton's memory will be cherished by members of the American Medico-Psychological Association as an earnest, conscientious fellow and a wise counselor, while those whose privilege it was to know him well will also mourn the death of a staunch and gentle friend. His eleven years of activity at the Butler Hospital for the Insane attest in abundant achievement the success of his career as medical superintendent of that institution. During his administration he labored hard and effectively to sustain the traditions of a hospital made famous by distinguished predecessors. The Sawyer Ward and the later Goddard House represent in the main Dr. Gorton's own ideas of hospital construction, and are a credit to his enlightened conception of the modern exigency. He took a great interest in shaping legislation for the insane in Rhode Island and had the satisfaction of seeing on the statute-books, several years before his death, an act authorizing voluntary commitment. For many years he had striven for the recognition of insanity as a disease, insisting that it should be provided for, in court and out of it, as a diseased condition and not as a criminal vice. He was also zealous in seeking relief, by appropriate legislation, for inebriates, his plan being to commit such cases to Butler or the State Asylum upon the certificate of a physician as to the fact of intemperance, the admission of the patient thereto and his consent to such commitment for a time not less than six months. The unselfishness of Dr. Gorton is well shown in this proposed legislation, because such an act would necessarily involve the admission to the Butler Hospital of a class of patients who are always undesirable in a hospital for the insane. As a consultant as well as an expert in medico-legal cases, Dr. Gorton enjoyed a large esteem. His brethren in the profession honored him with

the presidency of the Rhode Island Medical Society. His well-considered reports were always pleasant and instructive reading. No reader of them could fail to be impressed with Dr. Gorton's keen—one might almost say, overweening—sense of responsibility. He was a man of great foresight and, in planning for the future, seems to have had constantly in mind what the conditions of space are likely to be at Butler many years hence. He was able by his appeals to the humanity and civic pride of the people, with the co-operation of his trustees, to enforce the claims of charity and secure important bequests. He wrought hard, to the detriment of health. In the summer of 1895, the trustees of Butler Hospital, realizing Dr. Gorton's physical necessities, almost insisted upon his taking a summer's leave of absence when he himself was loath to put the ocean between himself and his post. Speaking, in his report presented in January, 1897, of the conferences held between himself and his trustees on many subjects relating to the care of the insane, this passage is characteristic as showing Dr. Gorton's conscientious thought of the future in all that he did, as well as his apprehension, even at that time, that his own tenure of office and life might not be long:

"They are, however, an abiding evidence that we have, so far as we could do, kept in mind the responsibilities that devolve upon us, and that we do not forget, in the desire to perform our present duties, that we should be mindful of the obligations to which those who may hereafter be chosen to administer this great charity will succeed." And the man who succeeds Dr. Gorton will deserve well of his fellows if, at the close of his career, he shall leave behind him a record that may compare in endeavor and achievement with that of his much lamented predecessor in the superintendency of the Butler Hospital.

JOSEPH DODSON LOMAX, M.D.

Dr. J. D. Lomax, for many years Superintendent of the Marshall Infirmary at Troy, N. Y., died July 22nd, 1899, in consequence of an attack of apoplexy. He was a native of England, but came to this country when three years of age. His early life was devoted to teaching, but he afterwards pursued his medical studies

and graduated at the College of Physicians and Surgeons in 1862. In 1863 he was elected Superintendent of the Marshall Infirmary, and from that date until the close of his life was employed in the treatment of nervous and mental diseases. He was a medical expert and frequently appeared in the courts. He was highly respected by all who came in contact with him.

Book Reviews

Degeneracy; its Causes, Signs, and Results. By EUGENE S. TALBOT, M. D., D. D. S., Fellow of the Chicago Academy of Medicine, etc. With 120 illustrations. (London, Walter Scott, Ltd., Charles Scribner's Sons, New York, 1898.)

As the author states in his preface, this work "is the result of more than twenty years' labor in a limited medical department of biology." As a practicing dentist, his attention had been more and more called to certain defects, local and constitutional; and his studies of them, largely embodied in his earlier work on the "Etiology of Osseous Deformities of the Face, Jaws and Teeth," and in numerous papers in medical and dental periodicals, form the basis of the present work. Here, however, he has widened his field and adopted a more popular mode of presentation of his subject, taking up not only the facts and their causes but also their treatment and prevention.

The first chapter is historical; in the second, he states his definition adopted from Ray Lankester, that "degeneracy is a gradual change of structure in which the organism becomes adapted to less varied and less complex conditions of life," and it is only when the total result in all the organs is such as to leave the whole in a lower condition that the individual can be called a degenerate. The scope of degeneracy may, therefore, be limited to certain signs, which are its sole expression—the so-called stigmata and their significance must be estimated by a careful study of the whole organism. The depth or degree will be shown by the way these stigmata involve the earlier simpler or the later more complex acquisitions through evolution. The face and brain being both comparatively recent are both likely to become affected and in the very highest species, man, both are among the first to show the stigmata, the former in the physical features, the latter in its functions and then reflected on the various organs over which it presides. In the apparent manifestations, however, the face and its appendages come first in attracting attention; hence their importance and the space given to them further on in this book. Dr. Talbot gives a classified table summarizing the stigmata ranging from cerebral, including ethical, intellectual, and sensory degenerations, through nutritive types down to local reversionary tendencies.

The immediately succeeding chapters, on heredity, intermarriage, race mixture, the influence of toxic agents, of climate, soil and food, and the effects of school strains, are full of interesting matter and show a wide

range of reading and thought on these subjects. The author is no follower of Weismann in his rejection of the inheritance of acquired defects, a view which does not hold its own well with pathological facts, as is here shown. Dr. Talbot's own investigations as to the effects of circumcision upon the Jews are, with the prior observations of Wolf and Remondina, rather strikingly to the point, as an evidence of inheritance of artificial defects in the human species.

Another interesting point, considering the fact that the work was written before the recent revival of interest in tropical disorders, is the conclusion reached in regard to the effect of climate in causing race degeneracy. Dr. Talbot finds as the general result of his studies that while climate has an undoubted effect its deleterious action is easily overestimated, and that results due to ignorance, carelessness, etc., are wrongly charged to its agency. The alleged degenerative action of the American climate on the white race, in regard to which there has been and still is much reckless pseudo-scientific assertion is rather graphically disposed of by an illustration of four generations of a prominent New England family which hardly indicates any such effect of American climate or environment.

In the chapters on the degenerate cranium and appendages, especially the jaws and teeth, Dr. Talbot is on familiar ground and can speak with authority, and the data collected in his earlier work are here utilized as far as needful. The chapters on degeneracy in the bodily organs and on the brain are worth reading as containing many suggestive facts and ideas, and this is still more the case with those on mental and moral degeneracies. The concluding remarks on the treatment and prevention of degeneracy are generally sound and show that the author is no pessimist in regard to his subject. In fact, accepting the definition he does accept, such could hardly be the case unless he were to hold that evolution has had its day and devolution, if we may so call it, is to take its place. His work will have its place in the literature of the biology and sociology of our species; and while not all of us may accept its views in every respect, it will be admitted that it embodies the results of very extensive study and wide reading. There are many things in it well worthy of the alienist's attention.

Nervous and Mental Diseases. By ARCHIBALD CHURCH, M. D., Chicago, and FREDERICK PETERSON, M. D., New York. 1 vol. 8vo. pp. 816. Sanders, 1899.

As the title indicates, this book is divided into two portions, the one treating of diseases of the nervous system, the other of mental diseases. The section on neurology comprises 600 pages, that on psychiatry but a little over two hundred. Each part is in a measure complete in itself, and has no direct reference to the other portion.

In his opening chapters, Dr. Church devotes an unusual number of carefully written pages to the examination into the anamnesis and general

physical examination, especially with a view to discover the stigmata of degeneration; and to minute methods of investigation into departures from the normal in the functions of the muscular and sensory systems, the special senses and speech organs, detailing the elaborate apparatus now used in neurological diagnosis. The chapters on "Diseases of the Brain Proper" are particularly clearly written and are perhaps the best in his section of the book. Some peculiar orthography, neither pleasant to the eye nor authorized by recent dictionaries, is occasionally noticed; decad, bromid, miosis, being among the number. A number of anatomical errors that are of moment are also seen in the text. On page 156, in describing the arrangement of the cortical vessels, the author states that "arising from considerable arteries in the arachno-pia, we have first a system of short capillary vessels that nourish the cortex." The *arachnopia*, or outer lamina of the soft meninges, contains no vessels of any size, and the entire nutrient supply of the cortex is derived from the vessels coursing in the internal or visceral layer. Again on page 71, we find that "the great pyramidal cells and large glial cells of the cortex are encapsuled by diverticula from the perivascular lymph channels, and are thus nourished." The derivation of the lymph-space of the pyramidal cells is correctly given, but with the exception of a diagrammatic drawing in Tuke's "Insanity of Over-exertion of the Brain" there is no warrant for ascribing a similar anatomical arrangement to the large vascular neuroglia cells; and it is not demonstrable by any known method of preparation, and would be rather a hindrance than a subservience of their function.

It is impossible in the space of 200 pages to give a full and accurate account of all the numerous aspects of insanity, and Dr. Peterson does not attempt to do so, but chooses the ones of most practical moment. His classification has the merit of extreme simplicity, comprising mania, melancholia, circular insanity, epileptic insanity, dementia (primary and secondary), general paresis, paranoia, idiocy, imbecility and feeble-mindedness. Unfortunately, there is no room in this classification for the finer subdivisions of mental diseases. The vast class of intoxication insanities from chemical poisoning, in their multitudinous aspects, are unrecognized; acute delirious mania (delirium grave), is placed among the group of ordinary manias; the septic and auto-intoxication group, a frequent form—and one of the most curable—of mental troubles, is not treated beyond a general outline in the chapter on the etiology of insanity.

The tendency of the past two decades in neurology has been to refine the symptomatology, and to create subdivisions out of general ones, with obvious benefit to the science. What is needed to advance psychiatry is not generalization, but the minute study of each individual case, and segregation into definite subdivisions of general groups; and until such study is made, the specialty will stand at its present level.

Decidedly the best chapters of the second half of the work are to be found in Dr. Peterson's especial field, idiocy, imbecility, and epilepsy. Many of the illustrations for this section are extremely interesting.

H. J. B.

Studies on Ganglion Cells. By JAMES EWING, A. M., M. D., Clark Fellow in Pathology. (Archives of Neurology and Psychopathology. Vol. I, 1898.)

This monograph is made up of 160 pages of text and is illustrated by six plates. The author's chief aim has been to study critically the claims made by the chief investigators within the last decade as to the fine structure of nerve-cells, and to determine what significance may be attached to the various cellular alterations which have been described. The author is certainly to be congratulated upon the spirit of fairness with which he has carried out the critical portion of his task, as well as upon the absence of any dogmatic tendencies in stating his own views.

The first part of the monograph is devoted to a historical review of the introduction and purposes of the chief methods in the study of the nerve-cell. The important influence in these cytological studies of the introduction of Nissl's methylene-blue method is referred to. The author evidently shows that he is not quite clear in his own mind as to the various steps in the use of this method—an uncertainty which he shares with many other investigators, for we are not aware that Nissl ever published this method in detail, although at various times the Heidelberg investigator has severely critcised the errors of those who have done their best with the aid of the few suggestions that he has hitherto published as to his technique. We cannot agree with the author as to the value of formaline when used alone as a fixing agent. In combination with a saturated bichloride solution, however, it is, as he suggests, a very valuable fixative. We cannot uphold the author as to the importance of Held's methylene-blue and erythrosin stain, especially as the pictures given by that method have not yet been confirmed by those given by any other stain. There is also some ground for skepticism in regard to the author's conclusions in describing the relation of the chromatic and achromatic portions of the nerve-cell. The fact that the specimens from which the drawings were made for Figs. 1, 2 and 4, Plate I, were fixed by heat suggests the possibility of the presence of artifacts.

The study of "the post-mortem changes in nerve-cells" is an excellent contribution to this subject and its importance has been very justly emphasized. The section on "the significance of the chromatic bodies" is a very timely and conservative statement, and the author, while expressing the belief that "the chromatic substance is related to the activities of the cell," in view of the present limited knowledge on the subject, refuses to define that relationship more exactly.

In Section VIII, on "the general Character of the Lesions in Nerve-Cells," it is said that it is far from certain that the achromatic substance ever really exhibits an increased affinity for methylene-blue. This is a statement the truth of which more recent investigators have not confirmed. A marked affinity of the achromatic substance for methylene-blue is to a certain extent characteristic of certain lesions. It is often seen in sections from the cerebral cortex in cases of dementia paralytica.

Mad Humanity, its Forms Apparent and Obscure. By L. FORBES WINSLOW, D. C. L., Oxon.; M. B., LL. M., Camb., etc. (New York, M. F. Mansfield & Company.)

The author tells us that the object he had in view in writing this book was to place before his readers "the most important features and characteristics of a terrible complaint which is causing much suffering and misery at the present day." "I have endeavored to show," he says, "that the increase of insanity, which has been of a progressive nature for many years, is real and not apparent." "I have clearly shown that much of this increase," he continues, "is due to that terrible vice—indulgence in alcohol—and the facts, as placed before my readers, and the cases illustrative of this point, I consider to be conclusive." While there can be no doubt of the wisdom of increasing the knowledge of the laity as to the causes of insanity and, to some extent, the care of the insane, we have strong doubts as to any good purposes being accomplished by the work under review.

The history of mad-houses, as the author calls them, which forms the subject of the first chapter, would probably be interesting and valuable if the author had not attempted to condense so much into so small a space, and if the names of those who have been prominent in all that has been accomplished in lunacy reform in England were not so wholly ignored. One would imagine that the names of Tuke, Connolly, Hill, Charlesworth and Shaftesbury had never been heard by the author. They find certainly no place in his work, nor is there any reference to the good that they accomplished. We have failed to see any reference to the work of the men who have made the care of the insane their study and who have reflected glory upon this department of England's public policy; but we do find frequent references throughout the work—intended, let it be remembered, for general reading—to what the author has accomplished and to the important cases in which his advice has been sought. For example, quoting from page 196, the author says: "The late Samuel Warren, a master in lunacy, always got assistance in his investigations by having one or more expert witnesses with him, and I was often employed in that capacity." We would commend to the author's attention the History of the Insane in the British Isles by the late Dr. Hack Tuke, from which he can gather much valuable information in case he should ever be called upon to issue a revised edition of the present volume. On page 4, in the History of Mad-Houses, Dr. Winslow states that Henry VIII. seized upon Bethlem Hospital in 1547, which up to that time had been used for a monastery, and presented it with all of its revenue to the city of London as a residence for lunatics. Henry VIII. did not seize the priory of Bethlem, although the author is not the first one who has made that misstatement. Bethlem was seized by the Crown in 1375, the forty-eighth year of the reign of Edward III. Richard II., Henry IV., and Henry VIII. all exercised their right to appoint masters of Bethlem. After an "inquisition" made in the fourth year of

Henry IV., 1403, the report of the Royal Commission states that there were six men confined at Bethlem who were lunatics (*sex homines mente capti*), so that the insane must have been received at Bethlem prior to this date. The statement that Bethlem was the first establishment for the insane founded in England is, moreover, not borne out by the facts, as there was in 1370 a hospital founded in the parish of Barking "for the sustenatation of poor Priests and other men and women who were sicke of the phrenzie, there to remaine till they were perfectly whole and restored to good memorie." What Henry VIII. did was to grant a charter on the 14th of January, 1547, a little over two weeks before his death, giving to the citizens of London, Bethlem Hospital, which had already been seized and was in possession of the Crown, the said citizens to be the governors, masters and rulers of the hospital. In the chapter on "Lunacy of the Present Day," the author deals in some rather curious statistics. From the table which he presents it appears that married women are more prone to insanity than married men; then follow married men, then single men, then single women, then widows and then widowers. The table which the author gives does not represent one-fifth of the entire number of insane in England and Wales, and he fails, although material is at his disposal in the Lunacy Reports of Great Britain, to give the proportion of insane married men or women to the whole population of married men or women in England and Wales, or the proportion of insane single men or women to the whole population of single men or women; had he done so, he would have shown not that married women and men are insane in greater proportion than single men and women, but, on the contrary, that celibacy apparently was more active in producing insanity. The Commissioners of Lunacy, the author states, make the following statement in their annual Blue Book:—"That we have been unable to satisfy ourselves that there has been any important increase of fresh insanity, and that the undoubted large progressive increase in the numbers of officially known persons of unsound mind has been chiefly due to accumulation, the result of the co-operation of several causes which we indicated, among which was a diminished discharge rate." From this view the author differs, as the result of his private experiences and of his experiences in his clinic and at the hospital. He states that the increase of lunacy is real and not apparent; that of this he has not the slightest doubt, and that this increase in lunacy is not confined to Great Britain, but is the same in other parts of the universe. This latter statement can be nothing more or less than an opinion, as certainly neither the author's private experience nor that at his clinic can afford any data as to the increase in lunacy in other parts of the universe. We have looked in vain for any statistics or any statement beyond the mere expression of an opinion by which the author endeavored to show, as he promised in his preface, that the increase of insanity was real and not apparent, and that much of this increase was due to indulgence in alcohol. A heterogeneous collection of cases, many of them selected because of their sensational aspects, or apparently be-

cause the author had been called as an expert, does not prove his assertion. The author is equally careless in his use of terms. He states in his preface that he has endeavored to be free from the use of technicalities, but certainly some of the terms that he uses are applied somewhat carelessly. The reviewer has always taught that insanity is an acquired condition. The author speaks of persons being "born insane." In a like manner we have always held that imbecility was an inherent state, while the author speaks of a case of insanity, of which he, however, gives the most vague outline, sinking into hopeless imbecility. He probably confuses the terms imbecility and dementia. Not only is the author careless in his use of terms, but in many instances decidedly careless in the construction of his sentences and in the use of ordinary terms. On page 81, for example, he says: "A lunatic, though also talking in an irrational manner, will nevertheless to a certain extent be intelligible. Those intimately associated with him will distinguish his meaning and what he wishes to infer." We are at a loss to understand how any one can distinguish what an insane person wishes to infer from what he says, although we can clearly understand that even during the greatest incoherence those familiar with a patient can distinguish what he is endeavoring to convey to another. We cannot understand how an author writing a book for popular instruction can excuse the very evident carelessness with which he has drawn some of his conclusions and the imperfect data upon which he has based them. As bearing out the statement which he makes that insanity is more prevalent not only in England but most other countries, among women than men, he gives the statistics of a large lunatic hospital in which he claims that 4,404 persons of unsound mind were admitted in a year, 2,622 of the female sex and 1,782 of the male. These statistics, which the author says show that 47 per cent. more females of the total number of admissions were received than male, may be taken, he claims, as a "fair criterion" of the ratio of insanity between the sexes. Let us see how correct these inferences are when examined in the light of facts. The total population by the census of 1891 of England and Wales is 14,052,901 men, 14,949,642 women; the yearly average of insane persons admitted to all institutions of England and Wales for the five years from 1888 to 1892 inclusive was 7,798 men and 8,246 women. If the author will compute the percentages in these figures, he will find that the percentage of men admitted is a trifle higher than the percentage of women, and had he been able to draw any conclusions from experiences in a large hospital extending over a series of years in which the records of admissions were carefully kept, we feel sure that he would have observed that the number of insane patients admitted, drawn from a population where the sexes were fairly evenly divided, is practically alike for each sex. We should like to know, by the way, the name of the "large lunatic hospital" where 4,404 persons of unsound mind were admitted during a year. No institution in Great Britain admits any such number during a single year, nor is there any institution which has even that number in residence. As an evidence of

careless reasoning, we quote from page 77 as follows: "It (kleptomania) is much more common in women than in men; it is rarely seen in the latter sex, except in school boys, when (*sic*) it is of frequent occurrence. The reason that it is more often found in women than in men is the fact that the former are more subject to attacks of hysteria, and such subjects are very liable to paroxysms of kleptomania, as well as to other forms of moral insanity." It now remains for the "author" to give us the "reason" why women are more liable to hysteria than men, and then the reason why the hysterical are more liable to paroxysms of kleptomania.

The work is embellished by a portrait of the author, as well as a number of photographs and with numerous specimens of handwriting. Much of this is without any real value, and, as far as the photographs are concerned, some of them fall far short of representing what they are intended to portray. What, for example, can be the value of the plate facing page 238 or that facing page 260, giving types of "mad women" and "mad men"? These pictures do not by any means portray typical cases of any recognized forms of insanity; or what, to continue, is the value of the plate showing cases of suicidal dementia? But we have occupied more space in noticing this work than it really deserves. It is decidedly not the type of book to place in the hands of the general reader, and for the library of an alienist physician it possesses no value whatever, except as a literary curiosity.

Correspondence

LETTER FROM DR. VAN GIESON.

To the Editor of the American Journal of Insanity.

Dear Sir:—Please accept our sincere thanks for your kind letter of June 16 calling attention to the pernicious influence on public opinion which newspaper articles might exercise in regard to the relation of our institute to the work of psychiatry and the hospitals for the insane. These articles attempt to intimate that our institute has given occasion for the belief that hospitals for the insane are becoming obsolete and useless, and the work of the alienist valueless.

It seems almost needless to point out that such intimations are absurd on the very face of them. No one in his right senses can possibly deny the paramount importance of institutions for the insane, both for society in general and for science in particular. One might as well declare against the utility of hospitals in general; for what is a modern insane asylum, if not a hospital for treating aberrations and diseases of the mind? It is only in the vulgar mind that we find survivals of the mediæval mode of regarding the asylum as a prison or as a house of detention. Surely none of the psychiatric profession who have taken the trouble to read the expositions of our aims and motives in the article entitled "The Correlation of Sciences in the Study of Mental and Nervous Disease"[1] can possibly even for a moment give credence to the preposterous insinuation that our institute in any way initiates the publication of such rubbish. Those acquainted with our aims and methods as formulated in this paper on Correlation know full well that our work is based on the hospitals for the insane and that our institute is intimately linked and interwoven with the life and existence of the asylum.

It is certainly unfortunate that the seeds of discord should be sown by the careless hand of the reporter, but it is really painful to find that a scientific institution should be held responsible for the vagaries circulated by newspapers for the amusement of their readers. A scientific institution situated in the maelstrom of a great city and doing work of a nature that lends itself for a sensational subject in a Sunday journal cannot escape the ever-watchful, searching eyes of the modern Argus —the newspaper reporter—with all of the consequent evils of absurd exaggeration and grotesque caricature. It is vexatious at first to see

[1] Archives of Neurology and Psycho-pathology, Vol. I, p. 25.

one's cherished work vulgarized, but in the course of time one learns by bitter experience the simple wisdom that such incidents are inevitable; that they must not be taken seriously, but good-naturedly, and treated in the way that they are intended—as fables, anecdotes and caricatures, useful as after-dinner reading; a stimulant to digestion.

IRA VAN GIESON.

Pathological Institute of the
New York State Hospitals.

[NOTE.—The above letter was received subsequent to the printing of the editorial note in the preceding pages.—EDITOR.]

A Quarterly Bibliography of Psychological Literature

(*Extracted, by permission, from the Index Medicus.*)

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